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Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

MEDICAL PREPAREDNESS

Medical Preparedness Is Not an Imaginary Need.—Physicians who have been reading recent reports on the progress of Medical Preparedness—as outlined in the *Journal of the American Medical Association*, CALIFORNIA AND WESTERN MEDICINE, and other medical publications—must certainly and before now have come to the conclusion that the American Medical Association Committee on Medical Preparedness, working through the constituent state medical associations and they, in turn, through component county medical societies, is in deep earnest in its efforts to promote every measure that can assist the medical corps of the United States Army and Navy to meet, in fullest measure, their present and future obligations.

* * *

Significance of Medical Preparedness.—In all massive projects, such as that of Medical Preparedness for the United States, a beginning must be made somewhere.

Medical Preparedness—the term is used here in the broad sense of the highest type of service in both military and civil work, even though at the present moment the military phases seem paramount—deals primarily, as regards personnel, with licensed physicians and their professional qualifications. It becomes immediately evident, therefore, why accurate knowledge concerning physicians should be available to the constituted national authorities, upon whom will fall the task of selection of the medical men for specific types of service.

Keeping in mind the peaceful relations which the United States has maintained with other nations on the American continents, it is understandable why, at the present time, commanding officers and staffs of the medical corps of the Army and Navy do not have in their files in Washington, and elsewhere, much informative data concerning the 175,382 physicians licensed to practice in one or more states of the Union. California, for instance, according to the *American Medical Directory*, 1940 edition, has 11,909 physicians authorized to practice and care for the 6,873,688 citizens of the Golden State. Of this number of physicians, 6,507 are members of the California Medical Association.

† Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

Action of the House of Delegates of the American Medical Association.—Shortly after the existing emergencies for an M-Day arose, the House of Delegates of the American Medical Association was in session in New York City, and that body instructed its officers to give prompt and fullest cooperation to the Surgeons General of the United States Army, Navy and Public Health Services, to the end that all needs of the Government might be adequately met. That is why the American Medical Association questionnaires were sent to every licensed physician in the United States, with a request that the information desired be forwarded promptly to the American Medical Association headquarters at 535 North Dearborn Street, Chicago. Unfortunately, the significance of the questionnaire was not sensed by many physicians. The California Medical Association will still send the necessary blanks to all requesting them, and physicians who have not mailed their questionnaires to Chicago are again urged to do so. California's record in this matter must eventually compare favorably with those of other state medical associations. At the time of this writing, however, it does not, for only about 54 per cent of California physicians have replied.

* * *

Important Meeting in Chicago on September 20.—On Friday, September 20, Doctor Philip K. Gilman of San Francisco, chairman of the California Committee on Medical Preparedness, and Doctor Charles A. Dukes of Oakland, a member of the American Medical Association committee, attended a meeting at Chicago at which representatives of the United States Army, Navy and Public Health Services explained the status of existing preparations, with special reference to plans for future needs. The *Journal of the American Medical Association* will no doubt print digests of the proceedings, and physicians who are interested should take the time to peruse the reports as they appear.

It has been estimated that it will be necessary to withdraw from civil practice, for service in the military arms of the Government, between five to ten thousand physicians, and it is the hope that this objective may be realized with a minimum of disturbance to civil needs, and a maximum of fulfillment in military objectives. The officers of the California Medical Association consequently urge all members to give wholehearted cooperation as needs may arise, by responding promptly to requests for information and work. Additional information concerning these activities is given on page 182.

COMPULSORY HEALTH INSURANCE: PROSPECTIVE REAPPEARANCE IN LEGISLATIVE SESSION OF JANUARY, 1941

A Recent Statement.—On page 107 of last month's issue, under the caption, "No Compulsory Health Initiative in 1940," CALIFORNIA AND WESTERN MEDICINE called attention to the fact that the threatened initiative for a compulsory health insurance law, to be voted on at the coming November election, had not materialized. But, as

repeatedly stated in editorial and other comments, the battle with proponents of a compulsory health insurance system for California is not over. No better evidence is needed for this conclusion than a broadcast by Governor Culbert L. Olson, so recent as October 1 and reported in the press, in which he said: "I should like to hope that the next legislature would tackle the problem of health insurance."

* * *

A Compulsory Health Bill Will Probably Be Submitted to the Next Legislature.—In the legislature of 1939, the State Administration submitted a compulsory health insurance plan that was publicized as one of its "must pass" measures. The proposed statute did not pass, but that does not mean that the sponsors of such a law have given up hope of its enactment in the near future.

Wherefore, it behooves members of the medical profession to acquaint themselves with the attitude, concerning public health problems, of candidates who seek election to the California Senate and Assembly. Only those aspirants for office whose past records indicate that they are in harmony with measures that make for the advancement of scientific medicine should receive the support of physicians.

OFFICIAL JOURNAL REPORTS BY COMPONENT COUNTY SOCIETIES: CHANGE IN PROCEDURE

Lesser Size of the Official Journal Creates New Conditions.—The lesser size of CALIFORNIA AND WESTERN MEDICINE—made necessary in order to lessen printing expenses—has led the Committee on Publications to consider how best to maintain the various departments of the OFFICIAL JOURNAL without materially reducing its informative text. At a recent meeting of the Committee the department for county society letters was carefully considered, and after discussion the conclusion was reached that the space heretofore devoted to county society letters from only a very few of the forty component county units could be made to bring a larger and better return to the Association if, in lieu of a few letters from a limited group, more comprehensive reports on a year's work from each of the forty societies were printed in December issues.

To attain this end, suggestive forms will be sent, in due course, to all county societies. Under the present system the State Officers and the headquarter's office have only sparse information concerning the activities of many of the component units. With proper cooperation, it is believed the factual data desired and actually needed could be made to be of greater value to all Association officers, while the recital of achievements by vigorous county societies would be of suggestive service and have a more stimulating effect for component units whose members were missing some of their opportunities for broader service. The indulgence of county societies, therefore, which in the past have sent in monthly letters, is requested until the new plan has been given a trial. At the same time, thanks are rendered for cooperation already given.

EDUCATIONAL NUMBER OF THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

Issue of August 31.—Every year the *Journal of the American Medical Association* places before the medical profession of the United States one of its weekly issues, labeled with the special caption, "Educational Number." The informative data concerning medical education in the United States presented therein is little less than encyclopedic in its scope, with the advantage of terseness and exactness in text and tables, made doubly necessary by demands on the *Journal's* space. Members of the California Medical Association who failed to scan the pages of statistical facts and explanatory text, as given in the Educational Number of August 31, should take time to at least check on California or home state figures, school of graduation and other information of interest.

Two features or chapters are especially commended:

1. Continuation Courses for Practicing Physicians—Clinical Conferences, Graduate Assemblies and Intermittent Courses; and

2. Approved Examining Boards in Medical Specialties.

* * *

Postgraduate Activities.—The paragraphs and tables dealing with Continuation and Clinical Courses reveal how important postgraduate work is construed to be by other state medical associations, and indicate how, in other commonwealths, state agencies and medical schools have found it possible to join with constituent state medical associations and local societies in developing an increasing interest in follow-up courses for physicians who are in private practice.

The need of every physician remaining alert to the rapid advances in scientific medicine has been so often emphasized that it is no longer necessary to discuss that phase. It must be apparent to all who ponder on the modern methods in medical practice that members of the healing-art guild who do not make an effort to keep abreast of the newer researches, knowledge and procedures, almost invariably lay for themselves a foundation for retrogression in both methods of practice, and in lesser number and less desirable kinds of patients. A heavy price to pay for indifference to advances in scientific medicine!

* * *

Statistical Comparisons.—In making comparisons on what this, that or the other state is doing in continuation courses for physicians in practice, it is necessary to take into account many factors, such as size of the state, distribution of its population, ease of intercommunication, agricultural, industrial, economic, social welfare and other conditions. In California, for instance,* Alpine is a constituent county unit covering a geographical area of 770 square miles with a population of 319, and not a single physician in the county. Another example: Mono covers 3,030 square miles, with a population of 2,283, and has one Doctor of Medicine residing within its confines.

* See table in CALIFORNIA AND WESTERN MEDICINE, September, 1940, page 148.

In California's fifty-eight counties, with the 1940 census population of 6,873,688 human beings, other examples might be cited, the same being of special interest, since some of these counties are also in the lists of counties in the United States, so often quoted as not being supplied with a single physician.

Be it said, however, to the great credit of the members of the medical profession in some of the sparsely settled counties of California, that they are alert to the advances in modern-day practice and meet their manifold responsibilities in splendid manner, in spite of comparative professional isolation. That, though, does not lessen the responsibility of carrying to them and also to many physicians in what might be termed isolated districts located in metropolitan areas, the message and opportunity for further advancement in medical practice.

* * *

How May Continuation Courses Be Instituted?—How, then, it may be asked, is this real task to be accomplished? The answer is, through recognition by officers of the district and county medical societies in California of their responsibilities in doing their part to make available to the physicians in their communities the courses offered by the California Medical Association Committee on Postgraduate Activities. California's record in postgraduate or continuation courses will not be up to standard until such time as, in every part of California, it will be possible for every physician to attend, once or twice yearly, a clinical conference or follow-up course of one or more days' duration.

The State Association Committee stands ready to cooperate with every local unit that desires such work, and will do its utmost to aid in the selection of topics of interest and of guest speakers whose talks would have practical and other value. If local officers are tardy or reluctant in taking up this much needed activity, correspondence is invited from individual members. The State Committee seeks to know who are the physicians in the various communities who desire continuation or refresher courses; for with groups of interested colleagues, the work can then be instituted.

Letters to the Association Secretary, who acts also in secretarial relationship to the California Medical Association Committee on Postgraduate Activities, will receive prompt attention.

* * *

Examination for Certification in One of the Specialties.—Reference was also made in the American Medical Association Educational Number to the national "Approved Examining Boards in Medical Specialties," of which there are fifteen, as follows:

American Board of Anesthesiology
American Board of Dermatology and Syphilology
American Board of Internal Medicine
American Board of Obstetrics and Gynecology
American Board of Ophthalmology
American Board of Orthopedic Surgery
American Board of Otolaryngology
American Board of Pathology
American Board of Pediatrics

American Board of Psychiatry and Neurology
 American Board of Radiology
 American Board of Surgery
 American Board of Urology
 American Board of Plastic Surgery
 American Board of Neurological Surgery

Detailed information concerning history, personnel, purposes, qualifications for eligibility to certification, examinations, fees, etc., are given for each of the boards mentioned in the *Journal of the American Medical Association* for August 31. Younger members of the profession, who may have in mind ultimate transfer from general to special practice, are urged to read the provisions laid down for the specialties with which, at some future time, they aspire to associate themselves. The ambition of physicians to prepare themselves to do work in which they have a special interest, and according to the best standards, is always laudable, and the continued study for such an objective makes for keenness of perception in both general and special practice.

These brief comments on two of the features in the Educational Number of the *Journal of the American Medical Association* should indicate why all readers who failed to notice that special issue, should take time to look it over. The factual data presented are as true and pertinent today as when given their initial presentation in the issue of August 31.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 180.

EDITORIAL COMMENT†

VIRUCIDAL ENZYMES IN NASAL SECRETIONS

Burnet, Lush, and Jackson¹ of Melbourne, Australia, report the discovery of a highly specialized virus-inactivating enzyme in human nasal secretions. Since this enzyme is particularly active against influenza virus, their discovery may conceivably pave the way to an effective clinical control of this disease.

That mucous surfaces are self-sterilizing has long been the opinion of clinicians. The earlier immunologists would account for this sterilization as the result of mechanical cleansing, plus the inhibiting action of traces of humoral antibodies and of lysins set free by disintegrating leukocytes. The first definite proof of a new type of chemical de-

fenses on mucous membranes was the discovery and isolation of the Fleming "lysozyme." Although this relatively simple chemical substance was found to be practically inactive against pathogenic bacteria, it did cause an immediate disintegration of certain nonpathogenic forms (*M. lysodeikticus*). Dold and Weigmann² afterward demonstrated other nasal (or salivary) "inhibins," active against diphtheria bacilli. The occasional presence of poliomyelitis-inactivating substances was subsequently reported by Howitt.³

The Australian investigators perfected methods of obtaining undiluted nasal secretions in relatively large volumes. A roll of gauze or absorbent cotton was pushed well up into each nostril and withdrawn at the end of thirty to sixty minutes. From each well-soaked plug about one cubic centimeter of nasal secretion could be wrung out by means of artery forceps. Pooled secretions were centrifuged and sterilized by filtration through a gradocol membrane.

Filtered exudates thus prepared were found to inactivate all strains of the influenza virus thus far tested, the reaction reaching a maximum after two hours' incubation at body temperature. The reaction was inhibited at low temperature. The active agent was destroyed by boiling. Many other viruses were tested and found to be wholly unaffected by the filtered secretion. These refractory viruses included: vaccinia, fowl-pox, rabbit myxomatosis, ectromelia of mice, infectious laryngotracheitis of fowls, and pseudorabies. Very slight virucidal effects were demonstrable with psittacosis, poliomyelitis and Rous sarcoma viruses. Well-marked antiseptic action was demonstrable against herpes, louping ill and virus B. Bacteriophages were wholly unaffected by the nasal secretions.

From available chemical evidence Burnet and his coworkers conclude that the virus-inactivating agent is not identical with lysozyme, or any other nasal antiseptic thus far studied. They believe that the virucide is a highly specialized enzyme, relatively specific for a narrow group of viruses. Whether or not the Burnet enzyme plays a significant rôle in the epidemiology of influenza is now the subject of statistical study. Attempts to isolate and identify the enzyme are also in progress.

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ATYPICAL CORONARY OCCLUSION*

In recent years interest in coronary thrombosis has been stimulated by the increased incidence reported within the medical profession as well as among the laity. In our minds, sudden closure of a coronary artery generally elicits a picture of severe chest pain or prolonged substernal oppression. Yet it has been established that painless plugging of a coronary artery does occur when even a large artery is involved.

² Dold, H., and Weigmann, F.: *Ztschr. Hyg. Infektionskr.*, 116: 158, 1934.

³ Howitt, B. F., *J. Infect. Dis.*, 60: 113, 1937.

* Condensed from paper read before the Los Angeles Heart Association, February 14, 1940.

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

¹ Burnet, F. M., Lush, Dora, and Jackson, A. V.: *Brit. J. Exper. Path.*, 20: 377, (Oct.), 1939.

In the series of cases published by Davis,¹ approximately 40 per cent were asymptomatic or without a history of pain. The mechanism generally agreed upon is that certain areas of the heart are not only less vital than others, but also less sensitive. But even if not relatively insensitive, they may become so by sclerotic processes occurring in the artery with concomitant fibrotic changes in the myocardium. Upon ageing, the scar tissue contracts obliterating vessels, myocardial fibres and nerves—virtually an auto-anesthetization.

In the recently published studies of Blumgart² and coworkers, it is concluded that the syndrome is not always associated with prolonged substernal oppression or severe chest pain, symptoms which usually bear a direct relationship to the degree of myocardial ischemia. When the narrowing of the artery has been sufficiently gradual to permit the development of a compensatory collateral circulation, a final occlusion may be likewise asymptomatic.

Diagnostic difficulty may be minimized by keeping in mind certain pain equivalents expressed in terms of sudden failure of the left ventricle. The pain equivalents are the *immediate* symptoms and signs of acute heart failure including dyspnea, shock, cyanosis or ashen pallor, pulmonary edema and other features of acute cardiac failure.

The *delayed* signs and sequelae are similar to those found in typical occlusion with moderate fever, leukocytosis, increased erythrocyte sedimentation rate, pericardial friction rub, embolic phenomena, various arrhythmias, tachycardias and, finally, the distinguishing electrocardiographic changes.

In brief, atypical coronary occlusion is to be suspected in sudden failure of the left ventricle with acute pulmonary edema. There appears to be, furthermore, a direct correlation between the symptomatology as well as prognosis and the adequacy of the compensatory collateral circulation.

HARRY J. MAYER,
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DANISH TECHNIQUE OF ACTIVE-PASSIVE DIPHTHERIA PROPHYLAXIS

Fjord-Nielsen¹ of the State Serum Institute, Copenhagen, Denmark, currently reports that, with a proper time interval between serum and toxoid injection, a superimposed active-passive diphtheria immunity is clinically possible.

The theoretical possibility of simultaneously immunizing laboratory animals by injecting a mixture of antiserum and homologous toxin was quite effectively ruled out by Th. Smith² and other early investigators. In their hands such a mixture is less effective than antitoxin alone, and does not stimulate a later production of active immunity. Nor was combined immunization possible if the serum and toxin were injected separately. Apparently

the specific toxin and antitoxin unite to form a nondissociable toxin-antitoxin complex, therapeutically and immunologically inert.

Following recent studies of bacterial toxoids, this early clinical hope has been revived. It is conceivable that toxoids precipitated with aluminum or aluminum hydroxid, for example, might form a dissociable and, therefore, immunologically active complex with homologous antitoxin. If so, a simultaneous injection of specific antiserum and homologous aluminum toxoid might cause an immediate passive immunity, gradually changing into a relatively permanent active immunity. About three years ago this conception was confirmed by Schmidt-Burbach³ and his coworkers of Berlin, Germany. In their technique, guinea pigs were given antidiphtheritic serum intramuscularly, with a simultaneous injection of diphtheria alum-toxoid subcutaneously. They obtained an immediate passive antitoxic immunity which gradually decreased till the eighth day, when measurable amounts of autogenous antitoxin began to appear in the circulation. This secondary autogenous immunity reached its maximum in about thirty days, and remained at a fairly high level for several months. Over four thousand school children were subsequently tested by the new technique, with statistical results not yet published by the Nazi clinicians.

This new "blitzimmunity," however, was immediately challenged by Frey and Schmid⁴ of Vienna, who injected twenty children simultaneously with diphtheria antitoxin and alum-toxoid. The Austrian clinicians found no demonstrable autogenous antitoxin in these children on the twenty-eighth day. In their hands the suggested method was less effective than routine antitoxin therapy, since one of their patients developed diphtheria during the course of the attempted duplex immunization. A similar challenge was reported by Gundel and König,⁵ who found that a combined active-passive immunity is only occasionally possible in laboratory animals, and then only if a proper quantitative balance is maintained between injected antiserum and toxoid doses. They found so many individual variations in this quantitative relationship, however, as to render duplex "blitzimmunization" impractical in clinical medicine.

Fjord-Nielsen, however, alleges that the duplex method may be rendered clinically feasible by interposing a three- to seven-day time interval between antitoxin and toxoid injection. Even with a time interval as short as three days, a prophylactically adequate autogenous immunity may develop. With the recommended seven-day time interval, antitoxin formation is equal to that in control animals. The possible clinical value of the new duplex technique was under investigation at the time of the Nazi invasion of Denmark.

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¹ Davis III, N. S.: Coronary Thrombosis Without Pain, *J. A. M. A.*, 95:1806 (May 21), 1932.

² Blumgart, H. L., Schlesinger, M. J., and Davis, David: Studies on the Relation of the Clinical Manifestations of Angina Pectoris, Coronary Thrombosis and Myocardial Infarction to the Pathologic Findings, *Am. Heart Jour.*, 19:1-91 (Jan.), 1940.

³ Fjord-Nielsen, I.: *Ztschr. f. Immunitätsforsch.*, 97:306 (Jan.), 1940.

⁴ Smith, Th.: *J. Exp. Med.*, 11:241, 1909.

⁵ Schmidt-Burbach, A., and Dehmel, H.: *Zentralbl. f. Bakt.*, 140:237, 1937.

⁴ Frey, L., and Schmid, E.: *Ztschr. f. Immunitätsforsch.*, 95:486, 1939.

⁵ Gundel, M., and König, F.: *Ztschr. f. Immunitätsforsch.*, 92:235, 1938.

ORIGINAL ARTICLES

OBESITY*

By EDWARD H. RYNEARSON, M. D.

AND

ANNE WHITCOMB SPRAGUE

Rochester, Minnesota

OCCASIONALLY the medical profession hears of a new disease, but certainly obesity is as old as man. Christie has stated that as far as he knows, the first man to teach the world that obesity is a curable affliction lived in Paddington, England. His name was Banting, and he was employed by St. Mary's Hospital as an undertaker. So little was obesity considered a medical disease in those days that this undertaker took it on himself to address to the people "an open letter on corpulence," in which he extolled the method by which he himself had lost "2.5 stone," and had been converted, from a man who could not tie his own shoes or walk downstairs other than backwards, into a comfortable elderly gentleman.

ON TENDENCY TO OBESITY

Presumably, ever since there have been fat people, there have been those who say: "I get fat even if I don't eat a thing." One of the discussers of Doctor Sansum's paper made the statement that a patient could live on 400 calories a day and still remain obese. Can this be true? In other words, is it possible for anyone to remain obese when the calorie intake is markedly restricted? This type of discussion raises the question as to whether there are different types of obesity. Any number of classifications have been suggested^{16, 26} which imply that endogenous or "endocrine" obesity is a separate disease from the exogenous obesity which results simply from overeating.

There is, of course, no question but that certain individuals are "preordained" (to borrow a Presbyterian term) to one type of body architecture or another. Gurney listed evidence to suggest that obesity follows the Mendelian law. Ward stated: "The tendency of obesity to run in families has been definitely shown by the statistics of various writers, particularly Bauer's series which showed 88 per cent, and von Noorden's, 70 per cent, with a family history of obesity. Furthermore, Danforth reported a strain of yellow mice in which the tendency to obesity was transmitted as a unit character. Gurney's study of obesity showed 82 per cent of obese cases with one or both parents overweight. In his opinion, the inheritance of obesity is along Mendelian lines. Bauer found that only 2.6 per cent of a series of 275 obese patients showed an endocrine disturbance."

RÔLE OF ENDOCRINE GLANDS

There is no good evidence to incriminate the endocrine glands in most of the cases of obesity. Body

weight varies markedly with different diseases (Dunlop) and it is true that obesity is a part of the clinical picture produced by certain disturbances of the endocrine glands. But why should so much attention be given to the possibility of hypothyroidism as the cause of obesity when so few patients with true myxedema are obese? As a matter of fact, where the edema is lost, most myxedematous patients are thin! It is true that patients suffering from certain types of "hypopituitarism" are obese, but let us not forget that in Simmonds' disease, due to complete "hypopituitarism," the patients are extremely cachectic.

GREENE'S OBSERVATIONS

Greene studied 350 cases of obesity, 100 cases of chronic encephalitis, twenty-four cases of myxedema, twenty-two cases of pituitary tumor, five cases of suprasellar tumor and seven cases of diabetes insipidus. Low caloric diets were known to be employed for an adequate period of time by 146 of these patients, and all of them lost body weight satisfactorily. Greene emphasized the importance of appetite, exercise and other factors in the production of obesity and gave consideration to the fact that some types of pituitary disturbances are supposed to be responsible for obesity, whereas others are responsible for cachexia. One of his concluding statements was as follows: "It is difficult to detect any difference between the obesity which develops in association with long inactivity due to a fractured leg and that which develops with a long illness due to pituitary tumor, suprasellar tumor, chronic encephalitis or myxedema. One has to admit, however, that not all patients with fractured leg and so forth become obese but neither do all cases of myxedema, pituitary tumor and chronic encephalitis." Bruch studied in detail the growth and maturation of 132 obese children from two to thirteen years of age and compared them with normal children. She felt that in many instances the obesity was a manifestation of early maturation.

Such a discussion could be endless. Can anyone deny the truth of the statement that the only source of fat is food? It is impossible to disregard the important observations of workers in the field of metabolism such as Liberson, DuBois, Grafe, von Noorden and Means.^{33, 34} Careful evaluation of the work done by these men gives added weight to the concept that all obesity is due to an increased intake of food and that man must follow the laws of energy exchange.

STRANG'S CONCLUSIONS

Strang drew the following conclusions: "(1) The exchange of energy in the obese, when compared to what would be normal for them if on proper weight, is increased. (2) This increase in exchange of energy is of the same magnitude as of the surface area increase beyond that normal for them. (3) When obese patients are reduced by dietary measures alone, the exchange of energy diminishes proportionately much more than the weight or surface area. (4) In spite of this drop in basal calories the metabolism never goes below limits normal for proper weight. (5) This observation contrasts

* Read before the Second General Meeting at the sixty-ninth annual session of the California Medical Association, Coronado, May 6-9, 1940.

From the Division of Medicine, Mayo Clinic, Rochester, Minnesota.

strikingly with the extreme energy economy in the individual of normal weight who is reducing by diet, as is shown by comparison with Benedict's figures. (6) There is, therefore, no evidence of an energy economy in the obese."

OTHER OPINIONS

Lyon stated: "All cases, whatever their origin, have this in common, that the excessive storage of fat is only possible if the intake of food is greater than the amount metabolized. Capital can only be accumulated if income exceeds expenditure."

Newburgh and Johnston stated: "Obesity is always caused by an overabundant inflow of energy. The excess is deposited as adipose tissue. This disproportion arises from a variety of conditions that may be thought of under two general headings. The first group includes the various human weaknesses such as overindulgence and ignorance. The second group is composed of conditions that cause a decrease in the requirement for energy; such as lessened activity or lowering of the basal metabolic rate for any reason. If the long established food habits do not respond to this lessened demand, obesity is inevitable."

RELATIONSHIP OF OBESITY TO OTHER DISEASES

The relationship of obesity to other diseases has been emphasized by many authors. Joslin has long emphasized the important relationship between diabetes mellitus and obesity. He stated: "The chief constitutional feature in the onset of diabetes is overweight. Among 4,599 patients, 78.5 per cent of the males and 83.3 per cent of the females were overweight at the time of their maximal weight. In contrast with these figures, only 7.9 per cent of the men and 6.3 per cent of the women had always been underweight." Goodrich and Fetter and associates have also commented on this important relationship. Musser called attention to the coexistence of hypertension, obesity and hyperglycemia and reported that with reduction in weight there was a lowering of the blood pressure and a return of the sugar tolerance curve to normal. Newburgh and associates^{37, 40} raised the question as to whether mild hyperglycemia and glycosuria in obese, middle-aged individuals is true diabetes mellitus. They reported interesting observations in which all of findings of diabetes mellitus have disappeared following reduction of weight.

Other diseases are known to be associated with obesity. Master and Oppenheimer found hypertension in 67 per cent of the cases of obesity and observed a corresponding fall in blood pressure as the patient's weight-curve dropped. They found changes both on roentgenograms and electrocardiograms which suggested a distinct circulatory embarrassment in obese individuals. Walker stated: "Obesity is a menace by tending to promote diabetes mellitus, hypertension, cardiac failure, cholelithiasis, varicosities, sterility, arthritis, sweating, faulty gait, faulty posture, hernia, and by increasing the risks and difficulties during any operation." Beck and Hubbard have studied the blood pressure, sugar tolerance curve, and so forth of sixty-three patients before and after reduction of weight. Bauman gave the percentage ratio on actual to ex-

TABLE 1.—Percentage Ratio of Actual to Expected Deaths

Sex	Overweight, Pounds	Ratio, Per Cent
Men	5 to 10	100
	15 to 20	116
	25 to 45	127
	50 to 80	153
Women	15 to 30	119
	35 to 60	124

pected deaths for men and women who were overweight, between forty and sixty-two years of age, based on 744,672 life insurance policies as listed in Table 1.

IMPORTANCE OF DIET

The importance of diet in treating obesity has been repeatedly described.^{7, 29, 36, 43, 48} There is no evidence to indicate that any obese patient will fail to lose weight if he follows a diet which is planned to furnish less calories than are necessary for his normal caloric requirements. The reasons for most failures are either that the prescribed diet contains too many calories or that the patient is not following the diet.

A very interesting part of Doctor Newburgh's³⁶ paper is the account of a dialogue between a physician and a very obese high school girl who stated that she "didn't eat a thing." Before the dialogue was completed, several thousand calories had been accounted for. Doctor Tunbridge has this to say about eating between meals: "One can never rely on the patient's opening remarks concerning his daily diet. Very few people will admit to overeating. How often have you been told: 'Doctor, I am a poor eater.' There are two very obvious fallacies to this statement. First, obese patients are often very self-conscious of their overweight and, in consequence, eat little at meal-times, but between meals they are always nibbling. When one realizes that a two-ounce bar of chocolate, one pint of beer, the most polite of afternoon teas—a buttered scone, a piece of cake and a cup of tea—have a caloric value of approximately 300 and that the daily requirement of the average person is only 2,500 calories, it needs very few 'snippets' to yield an excessive intake of food. Too, patients have little idea of food values and if they miss what they call a square meal, they frequently take a sandwich or cakes in place of the said meal, the caloric value of the latter often being much greater than that of a square meal. For example, one-half pint of beer and an ordinary meat sandwich have a greater caloric value than a meal composed of a reasonable helping of roast beef, greens, potatoes, a cup of coffee, a biscuit and a small piece of cheese." An occasional "drink" may affect the degree of weight loss. McCullagh, in discussing the rôle of alcohol in the induction of obesity, emphasizes that alcohol itself yields 7 calories per gram, although the question remains unsettled as to whether it is utilized as food. No one can lose weight who cannot control his appetite. The rôle of appetite in the control of body weight

TABLE 2.—Rigid Reduction Diet

Carbohydrate, 44; Protein, 64; Fat, 17; Calories, 585							
Food	Break-fast Grams	Dinner Grams	Supper Grams	Total Grams	Grams		
					Carbo-hydrate	Protein	Fat
Vegetables, 3 per cent		150	150	300	9	3	0
Vegetables, 6 per cent				100	6	1	0
Fruit, 5 per cent		100	100	200	10	2	0
Fruit, 10 per cent	100			100	10	1	0
Vegetables or fruit, 15 per cent				100	15	1	0
Vegetables or fruit, 20 per cent				100	20	2	0
Cereal (dry)				100	80	10	5
Bread	10			10	5.3	.9	.2
Cream, 20 per cent				100	5	3	20
Cream, 40 per cent				100	3	2	40
Milk, skimmed			200	200	10	6	2
Bacon				100	0	25	50
Eggs	1			Each 1	0	6	6
Meat (lean)		90	90	180	0	45	9
Butter				100	0	0	85
Mayonnaise with salad oil				100	0	0	85
FOOD VALUE OF THE DIET				Total grams	44.3	63.9	17.2
Calories from carbohydrate					177.2		
Calories from protein					(4 calories for each gram) 255.6		
Calories from fat					(9 calories for each gram) 154.8		
Total calories					587.6		

has been described by MacLagan and Harrington. Evans and Strang, and Evans¹⁰⁻¹² have performed a splendid piece of work in emphasizing the importance of diets quite low in calories which contain adequate mineral and vitamin supplements in the effective reduction of any type of obesity.

Cole, Gray and Kallenbach, and Short all report satisfactory results when patients have been co-operative in following the diet. Short's patient lost 239 pounds while on the diet! Gray has published photographs of obese, adolescent patients cured without injections of any type, and these photographs I think should be memorized by all who are inclined to publish "before and after" photographs following some more dramatic type of treatment.

TREATMENTS OTHER THAN DIET

Treatments other than diet have been advocated from time to time. There are, of course, many claims of cures, later proven fraudulent, which have been brought to light and described in the *Journal of the American Medical Association*.¹ Thyroid extract has long been a popular drug for use in obesity.

The importance of insisting that the patient remain under continued observation while thyroid extract is being taken is emphasized by a report by Fancher of one patient who, without supervision, increased the dosage to 72 grains of thyroid extract a day. The use of dinitrophenol and desiccated thyroid has been most thoroughly reviewed by Simkins. The unfortunate results are well known to all. Raab and Werner and Weir have described the use of posterior pituitary extract. Lesses and Myerson report the use of benzedrine sulfate, and Hirsh prescribed propadrine hydrochlorid.

HOW SHALL DIET BE PLANNED?

If we are agreed that the use of a weight reduction diet is the best method for treating obesity, how shall we plan this diet? First of all, let us eliminate the fad diet from further discussion. These diets are often inadequate in proper food constituents and have nothing to recommend them. Great harm may follow the unwise adherence to an unscientific diet. Some obese patients will lose weight satisfactorily simply by eliminating from the

TABLE 3.—Rigid Reduction Regimen—Simple Foods

Breakfast		
Orange	100 grams	1 average orange
Bread	10 grams	½ thin slice
Egg		1 egg
Lunch		
Head lettuce	50 grams	¼ head
Tomatoes, stewed	100 grams	½ cup
Cold meat	90 grams	3 ounces
Peaches, canned	100 grams	½ cup
Dinner		
Carrot	12 grams	6 thin strips
Sauerkraut	125 grams	¾ cup scant
Milk, skimmed	200 grams	1 glass
Pot roast of beef	90 grams	3 ounces
Apricots, canned	100 grams	½ cup

diet those foods which are rich in fat and carbohydrate. Such a qualitative restriction is not always effective and more rigid dietary restriction may be necessary. Diets containing about 1,000 calories are effective in reducing the weight of most obese patients, but we wish to discuss a diet containing only 585 calories per day. This diet should not be used indiscriminately and should not simply be handed to the patient. We never prescribe this diet unless the patient's physical condition has been exactly appraised, unless the patient promises complete co-operation, and unless the patient will eat his meals under supervision in the diet kitchen for at least one week. This is an accurately planned diet which

TABLE 4.—Rigid Reduction Regimen, Fancy Foods

Breakfast		
Grapefruit	100 grams	½ small
Bread	10 grams	½ thin slice
Egg		1 egg
Lunch		
Shrimp salad		
Shrimp	90 grams	3 ounces
Celery	50 grams	¼ cup
Dill pickle	10 grams	½ pickle
Lettuce	20 grams	2-3 leaves
(Mineral oil dressing)		
String beans	70 grams	½ cup
Pineapple	50 grams	¼ cup
Dinner		
Beef broth	200 grams	1 cup
Celery	25 grams	½ small heart
Mushrooms	100 grams	½ cup
Cucumbers	25 grams	5-6 thin slices
Milk, skimmed	200 grams	1 glass
Broiled steak	90 grams	3 ounces
Strawberries	50 grams	¼ cup

TABLE 5.—Daily Vitamin and Mineral Supplements

Substance	Dose	Vitamin or Mineral	Quantity of Vitamin or Mineral	Cost in Cents
Halibut oil	1 capsule	Vitamin A Vitamin D	10,000 170	.012
Thiamin chlorid	1 mg. tablet	Vitamin B ₁	333	.02
Meads Brewer's yeast	12 tablets	Vitamin B ₁ Vitamin B ₂	240 240	.043
Tribasic calcium phosphate	2 heaping table-spoon-fuls	Phosphorus and calcium	4.4 gm. 8.5 gm.	.046
Total cost				\$0.121

should be weighed on food scales. The diet prescription is described in Table 2.

We do not advise measuring this diet, but we have listed the approximate measures in the sample menus. The first menu is composed of simple foods, easily and cheaply obtained (Table 3); the second consists of more fancy foods (Table 4).

This diet is deficient in certain mineral and vitamin supplements and unless these are prescribed, patients will complain of weakness and hunger. At present the cheapest and best way of administering these supplements is described in Table 5.

If a patient is to follow such a strict diet, he must be able to see the results of his faithfulness. This can only be accomplished by furnishing him with a chart on which his anticipated weight loss is graphically illustrated. This chart can be drawn only if we know his estimated weight loss per week. This is determined by multiplying his daily caloric deficit by 0.002. This factor was determined by Dr. R. M. Wilder⁵² as follows: If D equals the caloric deficit per day, then $\frac{D}{9.3}$ = grams of fat loss per day (since 1 gram of fat produces 9.3 calories). Since fatty tissue contains approximately 86 per cent fat, the figure obtained above must be multiplied by $\frac{100}{86}$, which gives the grams of expected weight loss per day. Multiplying this figure by 7 converts this

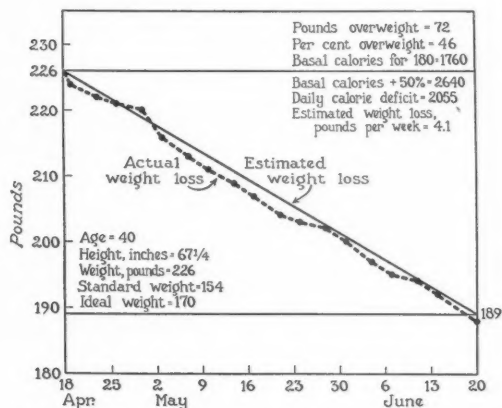


Chart 1.—Relation of predicted loss of weight (a) to the actual loss of weight (b).

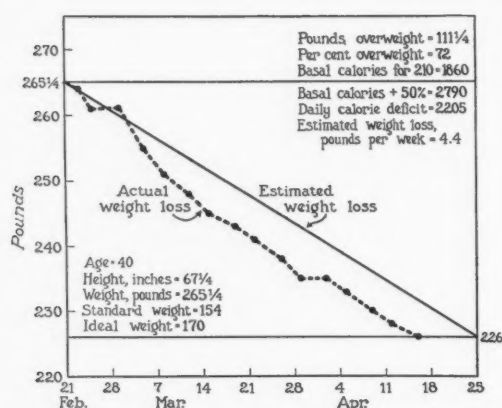


Chart 2.—Relation of predicted loss of weight (a) to the actual loss of weight (b).

figure to the expected weekly loss, and again multiplying by $\frac{2.2}{1000}$ converts the figures to pounds per week. In summary:

$$\frac{D}{9.3} \times \frac{100}{86} \times 7 \times \frac{2.2}{1000} = D \times 0.00193,$$

or approximately $D \times .002$. The following case illustrates the application of this method.

REPORT OF CASE

CASE 1.—A man, 40 years of age, was admitted to The Mayo Clinic on February 20, 1939, because of obesity and diabetes. He weighed 265 1/4 pounds (120.6 kilograms) and was 67 1/4 inches (168 centimeters) tall. The blood sugar reading was 138 milligrams per 100 cubic centimeters. The standard weight for a man of his age and height is 154 pounds (70 kilograms). We do not believe that standards should be followed too rigidly, and we arbitrarily selected 170 pounds (77.2 kilograms) as his ideal weight. He was, therefore, 111 1/4 pounds (50.6 kilograms) or 72 per cent overweight. All very obese patients lose more rapidly during the early weeks of their dietary restrictions than they do later, so that we plan the expected weight loss in several "steps." We planned the patient's weight reduction regimen so that he was first attempting to lose 55 pounds (25 kilograms), which would bring his weight to 210 pounds (95.4 kilograms). Using the Boothby-Sandiford tables, we find that the daily caloric requirements for a man forty years of age, who weighs 210 pounds (95.4 kilograms) and is at rest in bed are 1,860 calories. By adding 50 per cent to this figure for normal activity, we get 2,790 calories. By subtracting the 585 calories he is to be allowed, leaves a daily calorie deficit of 2,205 calories which, multiplied by .002, gives 4.4 pounds (2 kilograms), the estimated loss of weight per week. Fig. 1 shows that his loss of weight exceeded our expectations. The next table was planned in the same manner to reduce his weight to 189 pounds (85.9 kilograms). Again he was cooperative and again he lost the estimated amount of weight (Fig. 2).

By August the patient weighed 170 pounds (77.2 kilograms). He returned to the Clinic for reexamination and reported that while following this diet and taking the mineral and vitamin supplements he had been able to work every day at hard manual labor and had felt fine. His blood sugar reading and a sugar tolerance were within normal limits. A diet was prescribed containing 2,640 calories, which will enable him to maintain his weight at 170 pounds (77.2 kilograms).

CONCLUSIONS

All fat comes from food. Treatment for obesity is by the restriction of the intake of calories unless there is definite clinical evidence of an associated condition which requires special treatment. We have

never seen a patient who did not lose weight satisfactorily if this reduction regimen was rigidly followed. The addition of adequate mineral and vitamin supplements is an essential part of a rigid reduction diet, and very few patients complain of not feeling well when these supplements are taken.

The Mayo Clinic.

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(Continued in Back Advertising Section, page 40)

TRAUMATIC APPENDICITIS*

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AS used in this discussion, "traumatic appendicitis" may be defined as an inflammatory state of the vermiform appendix, resulting from extraneous mechanical injury. This definition thus excludes three other causative agents which might be construed as traumatic: (1) Bacterial trauma, following the usual infective invasion of the appendix; (2) Trauma produced by intraluminal foreign bodies themselves—for example, minute abrasions of the appendiceal mucosa caused by crystallized vegetable iron or by vegetable hairs (Shattock¹) or trauma caused by pins, seeds, worms, and so forth; (3) Trauma to the appendix when it is involved in an unrelated pathologic process, as when the appendix becomes strangulated in an inguinal hernia. This report is particularly concerned with appendicitis which follows severe forces applied to the abdominal wall. The subject is of importance, first, from a clinical standpoint, because of the possibility of including it among the clinical entities, and secondly, from a medico-legal standpoint, because of its occasional appearance in industrial compensation, accident

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insurance and liability litigation. In California, alone, the Industrial Accident Commission has reviewed fourteen cases between 1913 and 1937. In the forty-eight states the number must be well in the hundreds. The problem thus becomes similar to that of the relation of trauma to hernia. Inguinal hernia, even though known to result from developmental anlage, has become recognized as an industrial hazard, and now plays an important rôle in compensation cases.

TRAUMATIC APPENDICITIS, A CONTROVERSIAL SUBJECT

Traumatic appendicitis is a controversial subject. It is contended, on the one hand, that trauma is never responsible for appendicitis and, on the other, that trauma is of greater etiologic import than commonly is recognized. Deaver² stated that he never saw a case of acute appendicitis where injury was alleged to be the direct exciting cause, in which the appendix did not show evidence of previous disease. Foreign bodies, fecal concretions, strictures, and adhesions frequently are present without any suggestion of a lesion in the right iliac fossa. This view, however, is not inconsistent with the views of those who believe that appendicitis may be traumatic in origin.

Morehead³ stated that it is highly improbable that any violence could produce a lesion of such a deep-seated, movable, well-protected, tiny piece of intestine without damage to surrounding intestine nearer the source of violence and far more vulnerable. He saw no more relation between external trauma and appendicitis than between a blow on the neck and tonsillitis. Most textbooks agree that the appendix is immune to external violence or to the result of muscular strain on account of its deep-seated position and its mobility.

Murphy,⁴ in 1892, mentioned the possibility of traumatic appendicitis, but said that he had never seen a case. Von Neuman⁵ felt that trauma played a part in causing acute appendicitis in 6.6 per cent of all cases. Warbasse⁶ asked "if blows can rupture the normal intestine, why not the appendix?" Small⁷ believed trauma to be responsible for the increase in appendicitis over former years, and said that from 75 to 80 per cent of the cases of appendicitis in young adults resulted from trauma. Kelly,⁸ in his classical textbook, stated that not only does traumatic appendicitis exist, but that it is more common than is supposed, and is overlooked because no attempt is made to elicit history of injury. He reviewed fifty cases found in the literature. Osler⁹ wrote that persons whose work necessitates lifting heavy weights seem to be more prone to the disease. In his opinion, trauma plays a very definite rôle, and in a number of cases the symptoms have closely followed a fall or blow. The consensus of opinion in the literature is that there is a relation between trauma and certain cases of acute appendicitis. This is to be expected, since most reports include presentations of cases in support of the contention. Any controversial opinion arises from the fact that the appendix is commonly the site of infection, and that at operation it is not possible to discern a traumatic lesion which has

been overshadowed by an inflammatory one. As Ludington¹⁰ wrote, "No laboratory help has, in the past, been available to aid in the discrimination between traumatic and nontraumatic appendicitis, and as none seems likely to be forthcoming, the recognition of the traumatic case must, for the present at least, depend upon accurate clinical observation." White¹¹ said that when the appendix was removed and examination of the tissue made in the laboratory, it was impossible to say whether or not the condition of the appendix, which might be gangrenous and perforated, was caused by trauma.

Those favoring the existence of the entity argue that the mobility and deep-seated position of the appendix in the abdomen do not necessarily protect the organ, since the abdomen is not solid, but transmits force in directions other than the one in which it is applied. The gastro-intestinal content is a liquid-gaseous mass in which a force is transmitted equally in all directions. The deep location and mobility of the appendix, therefore, contribute neither to its vulnerability nor to its immunity.

Furbinger and Von Hanseemann¹² filled the cecum with colored fluid and were able to express the cecal contents into the appendix by light pressure on the ascending colon, and by the introduction of air into the rectum. They deduced from this experiment that a blow upon the abdomen could produce the same result. Van Buren,¹³ conducting experiments on dogs, found that increased intra-intestinal pressure created hemorrhagic changes at the antimesenteric surface of the intestine. In mechanical ileus, such hemorrhagic infarcts are found. These may lead to perforation of the wall.

PATHOLOGIC CHANGES

The local pathologic changes which may occur in the production of appendicitis from trauma are of five types:

1. Force applied to the external abdominal wall may cause a rush of cecal contents into the lumen of the appendix and produce actual rupture. This probably is rare.
2. Mucomuscular tears may be produced, resulting in areas of fecal stasis and invasion of the appendiceal wall. Narrowing of the lumen from any cause, particularly by the pressure of a fecalith, enhances this possibility. Aschoff¹⁴ stated that, since the lymph follicles of the appendix push forward as far as the mucosa, it follows that if any injury occurs the mucosa could be ruptured down through the capsule of the node. After careful search he frequently was able to demonstrate the very delicate fissures filled with fecal bacteria which extended from the lumen into the substance of the lymph nodes. The presence of fissures does not necessarily prove that trauma occurred, but their presence does indicate that the lumen has been over-distended to the point of rupture of the mucosa, allowing organisms to enter into the substance of the wall. Pus sometimes is found dissecting the mucosa from the muscularis.
3. The violence may cause impaction of a fecalith in the lumen, producing intraluminal stasis. Since the appendix cannot empty, a "closed loop" type

of obstruction occurs. Likewise, a highly infected nidus is produced, which cannot drain.

4. A hemorrhagic infarct may be produced with subsequent perforation.

5. The force may impact a fecalith against the appendiceal wall, causing a point of pressure necrosis. It is of interest to note that Brunig¹⁵ found concretions in 65 per cent of the appendices that were removed following trauma, and in only 35 per cent of those not associated with injury. Kelly⁸ reported fecaliths in thirty of fifty cases.

Aschoff¹⁴ found that the most active primary focus of infection was just distal to the site of the coprolith, and that a focus of secondary importance was at the proximal end of concretion. The area in actual contact with the concretion was usually free of infectious material, probably because the crypts were "ironed out," and thus were less subject to infection. It may be appreciated that, whatever the mechanism of the production of the appendicitis, the inflamed edematous viscus, covered with fibrin and filled with pus or perhaps gangrenous, will tell little of the story of its initial pathologic changes. Free blood in the peritoneal cavity or histologic evidence of trauma are requisite findings. Morphologic proof cannot be adduced because it does not exist.

Rare cases of actual evidence of trauma to the appendix, however, have been reported. Lupton¹⁶ recorded an instance in which the abdominal musculature was said to have been "bruised," and hematomata of the ileocecal and ceco-appendiceal junctions were found.

It has been said that one would expect it to be true that traumatic appendicitis is more prevalent in persons with thin anterior abdominal walls, or defective or poorly developed abdominal musculature. This has not necessarily been the fact in the cases reviewed. As far as the musculature is concerned, the contributing causes of any intra-abdominal traumatic lesion are that the muscle be in a state of relaxation and the application of force be sudden and unexpected by the recipient. Kicks, blows, athletic injuries, vehicular accidents, strains in lifting heavy objects, falls against protruding objects, industrial accidents, etc., variously have been accused as direct etiologic factors.

The immediate clinical picture is that resulting from pain at the injured site, and "peritoneal shock." The development of epigastric or periumbilical pain and vomiting usually follows closely upon the injury. Later, after a period of comparative quiescence, symptoms and signs characteristic of appendicitis develop.

DIAGNOSIS

Shutkin and Wetzler set forth the following postulates which they felt must be met before a diagnosis of traumatic appendicitis could be made:

1. There must have been absolute freedom from abdominal complaints associated with pain, nausea, vomiting and tenderness, before the trauma.

2. Direct trauma must be severe and forcible, involving the abdominal wall in the right half especially.

3. Indirect trauma must be violent, acute, and unexpected.

4. Symptoms must appear immediately after the trauma.

5. Symptoms must be persistent and progressive, assuming the symptoms and signs of acute appendicitis.

6. The pathologic findings must indicate a suppurative destructive or necrotic process.

Recognition of the possibility is the salient point in treatment. Surgical care then follows the precepts for the treatment of acute appendicitis.

MEDICO-LEGAL ASPECTS

As mentioned previously, the medico-legal aspect of the subject is of considerable import. Usually the courts have held against the casual relationship of trauma and the development of acute appendicitis, and on the basis of expert medical testimony have ruled that the inflammatory process was coincidental. Undoubtedly insurance carriers have paid many claims for so-called "traumatic appendicitis" either for "policy reasons" or because the history of the case probably warranted the payment of such claim. In our own series, three of the seven cases immediately followed bona fide industrial injuries. In each of these instances the insurance carrier awarded the claim without causing the employer to file a claim before the Industrial Accident Commission.

The following are abstracts of the cases ruled on by the California Industrial Accident Commission from 1913 to 1937. Of the fourteen cases, only four were adjudged compensable.[†]

REPORTS OF CASES

CASE 1.—Sergeant P. R., 37 years of age, fell in the armory and struck the right lumbar region on a gun rack; thence he fell to the floor, striking the abdomen. The injury occurred on August 14, 1923. The patient was immediately and totally incapacitated on account of continued pain in the right lumbar region and right lower quadrant. Two weeks after injury the patient began to have increasingly severe abdominal cramps and vomiting, loss of appetite, weakness, etc. He first sought medical aid on September 8, 1923, when examination was made which revealed a sick man with marked ecchymosis over the right lower quadrant and right hip. At operation on September 20, 1923, a gangrenous perforated appendix was found with large retrocecal abscess containing several fecaliths. Appendectomy was done and the convalescence was uneventful. (Compensation was awarded.)

CASE 2.—J. R., 21 years of age, a laborer, was struck in the lower part of the abdomen by a heavy timber on December 17, 1937. Within a few hours the patient began to develop increasingly severe abdominal cramps, and he was unable to void. When seen in consultation on December 19, 1937, the patient was acutely ill with the typical symptoms and signs of a diffuse peritonitis with paralytic ileus. Operation was performed on December 19, 1937. There was evidence of trauma to the abdominal wall. A large gangrenous perforated appendix was found lying just over the brim of the pelvis. There was a diffuse plastic peritonitis. (Note: The insurance company considered the case compensable.)

CASE 3.—F. D., police officer, 28 years of age, was "kneaded" in the right lower abdomen during a scuffle on October 1, 1937. The patient immediately developed pain

[†] Case reports not recorded here, appear in the reprints.

Decisions of the Industrial Accident Commission of California in Cases Claiming Traumatic Appendicitis
YEARS 1913 TO 1937

Case No.	Reference	Method of Injury	Decision
1.	3:84, 1916	Struck abdomen on plank	Compensation awarded
2.	3:225, 1916	Sprain while lifting	Compensation awarded
3.	7:114, 1920	Sprain while lifting	Compensation denied
4.	8:112, 1921	Struck abdomen on plank	Compensation denied
5.	8:102, 1921	Struck abdomen against tongs	Compensation denied
6.	9:159, 1922	Swallowing dust of mouldy grain	Compensation denied
7.	10:248, 1923	Setting window frames (no definite injury)	Compensation denied
8.	11:7, 1924	Fell, struck right side	Compensation denied
9.	12:30, 1925	Strain while lifting (appendix strangulated in hernia)	Compensation allowed
10.	12:214, 1925	Struck in abdomen by tongs	Compensation denied
11.	13:80, 1926	Sprain while lifting	Compensation denied
12.	13:69, 1928	Struck abdomen against rail	Compensation denied
13.	19:145, 1933	Sprain while lifting	Compensation denied
14.	19:46, 1933	Struck abdomen against counter	Compensation allowed

at the site of injury. He continued to work, though with difficulty, for three days. Urination and defecation greatly aggravated his abdominal pains. He was nauseated, but did not vomit until October 3, 1937, when the symptoms became severe. Operation was performed. The cecum and terminal ileum, and the mesentery were markedly edematous and infiltrated, and were covered with plastic exudate. The appendix lay over the pelvic brim. It was gangrenous in its distal two-thirds and was perforated. (Compensation was awarded by the San Francisco Retirement System.)

CASE 4.—W. B., 11 years of age, a schoolboy, was struck in the abdomen by a volley ball. Abdominal discomfort occurred immediately, but gradually disappeared. Except for a poor appetite in the evening, the patient had no complaints. He slept well and went to school the next day. Late in the forenoon he developed a generalized "bellyache." He was given milk of magnesia and later vomited. The pain soon localized in the right lower quadrant. Operation was performed the day after the injury. The appendix was found lying over the pelvic brim. Early gangrene was present.

CASE 5.—H. P., a truck driver, 24 years of age, who had been injured forty-eight hours before when he pulled on a rope which broke suddenly, causing him to fall backward and strike the posterior aspect of the right flank on a piece of machinery. He suffered severe pain at the site of injury. An hour and a half later he began to have cramp-like pain about the umbilicus, which became more severe. That night he vomited and the pain shifted to the right lower quadrant, where it remained. At operation purulent fluid was found to be present in the peritoneal cavity. The appendix was gangrenous, perforated, and adherent to a thick, inflamed mesentery, and to the lateral posterior aspect of the cecum high in the right flank.

CASE 6.—C. C., a schoolgirl, age 13 years. On April 24, 1929, the patient was struck in the abdomen by a baseball. She immediately suffered pain in the right lower quadrant. She vomited a few hours after injury. She was taken to the hospital on the morning of April 26, 1929. The urine showed some granular casts and a few red blood cells. At operation, through a Battle incision, an acute perforated appendix was found lying high in the right iliac fossa in a retrocecal position. The perforation was caused by a pin which was forced through the appendix in its middle third. The head of the cecum and the right kidney were covered with fibrin. The appendix was nailed by means of the pin to the right kidney by the force of the blow which struck the right lower quadrant.

CASE 7.—B. J., a schoolgirl, 9 years of age, fell on the sidewalk, striking the right lower quadrant of the abdomen on the curb. Symptoms which began at that time increased in severity. At operation, the peritoneum showed subserous hemorrhage in the region of the incision. In the right lateral wall of the cecum there was a subserous

hemorrhagic area about the size of a dollar. There were areas of old hemorrhage in the meso-appendix near its base. When the appendix was split, areas of hemorrhage into the mucosa were seen corresponding to the hemorrhage in the meso-appendix. Microscopically, hemorrhages were discovered in the germinal portion of the lymphadenoid tissue.

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OSTEOMYELITIS OF THE BONES OF THE FACE IN A SEVERE DIABETIC: WITH RECOVERY AND PLASTIC RECONSTRUCTION*

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OSTEOMYELITIS of the bones of the face and skull has always presented a difficult problem to the rhinologist. Its association with sinus disease was first recognized by Luc and Tilley in 1899. Dan McKenzie of London in 1913 reported forty-eight cases. Of these, in forty-five the origin

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Fig. 1.—Lesion early in the disease showing large sloughing area with necrotic bone exposed.

of the infection was traced to the frontal sinus, while three were from the maxillary sinus. He remarked that the disease rarely originated in the ethmoid, as the infection usually caused a fatal meningitis before a true osteomyelitis could develop.

The infection may be divided into two types—spreading and localizing. The dividing line may be accounted for, at least partially, by variations in bone formation, and type and virulence of the process. The spreading type is usually fatal, but the localizing is not necessarily so. *Staphylococcus albus* or *aureus* is the organism usually recovered, although streptococci and pneumococci may be found.

The case we had the opportunity to follow, in addition to being a severe localizing type of osteomyelitis, was complicated by an advanced diabetes.

REPORT OF CASE

A 14-year-old girl, with a negative family and past history, began to lose weight in the summer of 1936. It was noticed that she developed increased thirst and polyuria, and looked poor; but she was not taken to a doctor.

In July of 1937, while on a vacation in the southland, she was taken acutely ill with follicular tonsillitis.

She was seen by Dr. W. P. Garrison of Long Beach on July 22, 1937, who reported to us the following:

"Her temperature was normal and her pulse 82. She was complaining of vague, indefinite pain in the left side of her face, but there was no swelling or edema. She was placed in bed and given symptomatic treatment.

"The following day her condition had changed markedly. Her temperature was still normal, but her pulse was 120, respiration 40, and she was stuporous. She was hospitalized and found to be in diabetic coma. Her blood sugar was 365 milligrams per cent, her urine contained 4 plus sugar and acetone. She was given alkalies, subcutaneous fluids, and insulin; and because there was some slight redness of the left side of the face, protosil was given intramuscularly in 5 cubic centimeter doses every three hours.

"On the following day, July 24, there was definite redness of the left side of the nose and face, which appeared like erysipelas, although there was no line of demarcation. Fluids and insulin were continued.

"The next day, July 25, the right eye and right side of the face were involved. Protosil was continued, and prontosil was given, 5 grains every three hours. Quartz light therapy was begun locally. The diabetes was controlled with multiple injections of insulin, up to 90 units a day. The temperature was swinging. On this régime for ten days, the infection of the right face and eye were controlled, and the infection of the left side became less acute.

"On August 3, she was given a transfusion of 500 cubic centimeters of whole blood.

"On August 5, under local anesthesia, the left antrum was drained, and necrotic tissue was removed from the left side of the nose at the inner canthus of the eye.

"On August 13, she was transferred to San Francisco."

1 1 1

When first seen by us she was a sick, pale, dehydrated, emaciated girl, complaining of pain in the left side of her face and left eye. The left face showed marked edema and cyanosis of the upper and lower lids. At the inner canthus of the eye, there was an area of necrotic tissue of about 2 by 4 centimeters in diameter. The left eyeball was protruding, and fixed and markedly injected. There was an early corneal ulcer and pus in the anterior chamber, and vision was lost. The right face was normal. The right nostril was essentially negative. The left nostril was filled with foul-smelling, dirty, yellow pus. Upon removal of



Fig. 2



Fig. 3



Fig. 4

Fig. 2.—Active infection has subsided. Globe has been removed. Lower lid pulled downward by scar tissue. Anterior end of middle turbinate may be seen through the fistula.

Fig. 3.—Pedicle attached at lower margin of fistula.

Fig. 4.—Fistula closed. Final reconstruction has not yet been completed.

this, the entire lower turbinate was gangrenous, and there was pus in the middle meatus. The throat was essentially negative, except that there was a large amount of pus in the nasopharynx. The ears were normal. There was no regional adenopathy and the thyroid was normal. The heart was not enlarged. It was regular, with occasional premature systoles, tones were good. The lungs were entirely clear. The abdomen was negative; liver and spleen not enlarged. Extremities were normal. Blood count showed 48 per cent hemoglobin, red count 2,740,000, white count 4,600 with 63 per cent polys. The urine showed 4 plus sugar, no acetone; blood sugar 444 milligrams per cent. Her weight was estimated at 88 pounds.

Clinical Course.—She was placed on a diet of protein 80, fat 115, carbohydrate 220, a total of 2,235 calories, and this was given in frequent small feedings throughout the day and night, as tolerated, but it was seen that the total amount of 220 grams of carbohydrate was taken in daily. She was given a daily dose of 40 units of protamin insulin, and urine specimens were followed four times a day, and small doses of old insulin, ranging from 5 to 25 units, were given three to four times a day in an attempt to keep the urine nearly sugar-free and continually acetone-free. She was given two transfusions the first two days of hospitalization. The sloughing area on the left side of the nose was irrigated with Dakin's solution several times daily, and the left nostril cleaned with gentle suction at frequent intervals throughout the day. No attempt was made to irrigate the left antrum or disturb the necrotic tissue.

Because of the apparent control of the spreading infection, sulfanilamide therapy was not continued, although hemolytic streptococci had been recovered from the pus.

X-rays, taken on entry, showed thickening of the frontals and ethmoid cells on the right and of the left antrum. There was osteomyelitis of the nasal bone, extending down at the inner margin of the left orbit.

For the next two weeks the local condition in the face remained about stationary, with continual sloughing of the base of the external wound, but no evidence of spreading infection, nor was the patient septic. Her temperature was low-grade, and the white counts were all within normal limits. She took her diet well, and the urine was kept continually acetone-free, and she slowly gained weight. By the end of a month the sloughing tissue was all removed from the external wound, and an area of bare bone was left exposed. The bone was necrotic but was still firmly fixed, so it was not disturbed. The eyelids were still markedly swollen and the eye itself remained as on entry. She was gradually allowed to be up and around and was dismissed on the eighth of September on the same diet and insulin, weighing 93 pounds.

She was then followed at the office and the necrotic bone began to sequestrate. Day by day, small bits were removed until eventually the left lacrimal bone, frontal process of the maxilla, paper plate of the ethmoid, part of the nasal septum, and entire lower turbinate had been taken away. This was all accomplished without causing any severe hemorrhage. This left a hole in the face through which the entire nasal cavity could be visualized. The maxillary and frontal sinuses could be readily entered and all other intranasal structures easily identified. She steadily gained weight to 105 pounds.

On the morning of October 12, the girl developed an attack of acute appendicitis. Under spinal anesthesia, Dr. H. B. Stephens removed an acutely inflamed appendix, with fecalith. The wound was tightly closed with black silk throughout, and on return to her room the patient was given intravenous glucose and insulin.

The day following surgery she was given her full carbohydrate intake in the form of glucose and water by mouth, and her insulin was continued. The second day postoperatively she was given a light diet containing all her 220 grams of carbohydrates. The urine again was followed carefully and small premeal doses of old insulin were given to keep her relatively sugar-free, and at no time did she show acetone. No attempt was made to keep her blood sugars entirely normal.

On October 20, while convalescing from the appendectomy, the dead left eye, which had collapsed through perforation of the corneal ulcer, was enucleated under evipal anesthesia by Dr. J. L. McCool.



Fig. 5.—X-ray showing osteomyelitis of the left nasal bone.

On October 23 she was discharged, weighing 108 pounds.

Plastic Reconstruction.—On November 9 she reentered the hospital for plastic reconstruction. Examination showed a large oval defect extending from the supra-orbital ridge down along the lateral nasal wall to the level of the infra-orbital foramen, outward to the medial portion of the malar bone.

The stump of the lower lid was pulled down so that the nasal margin was at almost a right angle to its normal position. A portion of the nasal margin of the upper lid was lost.

The problem of reconstruction was difficult in that the tissue loss consisted of supporting structure, lining and covering in an area where ridges and depressions meet, as well as where thin skin joins with thick skin. It was complicated by the infolding and curling of the conjunctiva, loss of lid substance in both the upper and lower lids, and the marked ectropion of the lower lid stump.

A forehead flap with lining graft was seriously considered for reconstruction but abandoned because of our dislike to create one deformity to cure another. A tubed pedicle was made beneath the left breast, lengthened and transferred via the back in order not to scar the chest above the nipple line. By lengthening the pedicle the skin was brought to the defect and anchored at opposite edges in four major steps, leaving enough and more for lining and covering flaps.

The orbit was restored and made ready for the reception of the prosthesis, without the necessity of lining grafts by careful dissection of incurled conjunctiva. The bony support was taken from the right iliac crest.

COMMENT

From the beginning this patient presented many interesting and unusual problems. Early in the disease a clinical picture of erysipelas was presented, but this soon showed its true nature when the subcutaneous tissues at the inner canthus of the left eye began to break down.

The use of sulfanilamide in the early stages probably controlled the infection and accounted for the fact that it remained localized. Later on the problem of management of the necrotic tissue was paramount. This was done by allowing the fragments of bone to sequestrate the same as is done in osteomyelitis in other parts of the body. As soon as a fragment of bone became freely movable it was carefully lifted from its position. We believe this to be the main point in the rhinological management of the disease, as no severe hemorrhage occurred at any time. (Many of the cases reported were brought to termination by severe uncontrollable bleeding because of too early removal of the sequestra.)

During the course of the acute infection in this patient, and for each of the many operative pro-

cedures, the diabetes was handled with a relatively high carbohydrate diet, a daily dose of protamin-insulin and small premeal doses of old insulin to keep the urine relatively sugar-free and at all times acetone-free. There was no attempt made to keep the blood sugars within so-called normal limits. It was seen that each day the equivalent of at least 200 grams of glucose was taken by the patient in four meals or in multiple small feedings during the day and night, even on the day of her operations, any deficit being made up with intravenous glucose. It is felt that in combating infection it is essential that the diabetic as well as the nondiabetic have always available sufficient glucose and insulin for the increased metabolism, and that acidosis must not occur. It is also felt that high blood sugars *per se* do not make for increased hazard of infection or for poor wound healing. But when these complications are seen in diabetics they are due rather to the lack of available combustible glucose, and this may occur if the patient is not given sufficient glucose and insulin, even though the urine is sugar-free and the blood sugars are normal or low.

In a nondiabetic who goes through an operation, intravenous glucose is frequently administered immediately following surgery, and sometimes kept up for two or three days because the surgeon feels that this is necessary to ward off acidosis and other complications. During this period of glucose administration the blood sugar of the nondiabetic varies from normal to 700 milligrams per cent, and the patient continually shows sugar in the urine and yet does well. It is exactly with this in mind that this patient was given practically all the glucose she could take and plenty of insulin, to make sure she was burning her glucose after each operative procedure, with no attempt being made to keep her blood sugars within normal limits or the urine sugar-free.

While at home the diabetes was controlled with a single daily dose of 50 to 60 units of protamin-insulin. On hospitalization for surgery the protamin-insulin was cut to approximately two-thirds this amount, to give a constant supply of insulin without the danger of severe reactions, changing her in a manner from a severe to a mild diabetic. She was then allowed to eat when and as desired, and the carbohydrate intake was carefully measured and the urine repeatedly tested for sugar, small doses of old insulin being given as indicated. Many times during her operative procedures she went to surgery with blood sugars over 200 milligrams per cent, and had blood sugars ranging 200 to 300 milligrams per cent throughout the day following surgery. At no time was it shown that these high blood sugars, in themselves, detracted in any way from the rapidity of her wound healing, nor did she ever vomit or have acidosis.

With the diabetic control favoring healing, reconstructive problems in this case evolved around the location rather than the type of the defect. The tissue loss necessitated restoration of both thin skin for the lid area and thick skin for the nose and cheek. The advantage of the tubed pedicle flap over the lined forehead flap was its adaptability to these conditions, even though texture, color, and

thickness were factors in favor of the latter. Bony support was given preference over cartilage because it does not bend, resists infection, and unites readily to the underlying bone. Isografts were not considered.

This case illustrates well again the necessity for close coöperation among specialists when many are caring for one patient. Too often the patient is lost between "specialists."

SUMMARY

1. A case of osteomyelitis of the bones of the face, due to hemolytic streptococcus, in a 14-year-old, severe diabetic, with recovery and plastic reconstruction, is reported.
2. Sulfanilamide may have been an important factor in the localizing of the infection.
3. The conservative management of the bony sequestra in this type of case is emphasized.
4. A relatively high carbohydrate diet with insulin was used in the diabetic management, without particular care to the control of blood sugars.
5. The problem of restoring a bad defect in a difficult area on the face, complicated by the loss of the eye, is briefly discussed.
6. After careful analysis a tubed pedicle was used, in preference to a lined forehead flap, for restoration.
7. Autogenous bone grafts were used for support.

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INFANTILE ECZEMA: ITS DERMATOLOGIC MANAGEMENT*

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THE term "infantile eczema" is a general one, covering a number of different conditions. In recent years there has been agreement, for the most part, as to what is included under this term. For the purpose of this discussion on therapy, the following division is made: eczematous fungus infections; seborrheic dermatitis; contact dermatitis; atopic dermatitis. Frequently two or more of the above are present at the same time.

Correct diagnosis naturally is most important. This does not mean, however, that the treatment then is routine for each type of eczema. Infants with the same kind of eczema will show marked differences in their response to the same medication. A slight modification in the preparation may be all that is necessary to achieve good results. Frequently, a change to some other medication is essential.

GENERAL CONSIDERATIONS

The first problem in treatment nearly always is the parents. They are, of course, upset and it is important to have their coöperation. They should be told several facts concerning the disease. It is

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not contagious except occasionally in the fungus type, and the health of the baby is not generally affected. There is no residual scarring and the skin will return to normal. In regard to prognosis, the infant has a 90 per cent chance of getting over the disease between the eighteenth month and the second year.

Instructions should be given the family concerning the baby's surroundings. The room should be scantily furnished, the closer to bareness the better. Exposure to sunlight and wind should be avoided. Tight-fitting and irritating clothing should be done away with. The clothing and bed clothes should be made of cotton so that the child does not come in contact with any wool. Feathers should be eliminated from the room and the floor should be mopped frequently so that no dust or lint accumulates.

Soap is another irritating substance which should not be used. Baths can be given and it is well to add starch or oatmeal to the water. The one exception for the use of soap is in treatment of the scalp. Here it is of advantage in removing the crusts.

Pruritus is the most distressing symptom, and is present in all forms of eczema. This should be controlled because a short bout of scratching will change a mild dermatitis into a severe one. If the baby is excoriating himself, splinting or tying of the arms is indicated. Small doses of a mild sedative may be needed. Ideally, babies with any marked involvement should be hospitalized, as they respond rapidly to this change in environment. Osborn has clearly demonstrated this point in a large group of patients which did not respond at home to any therapy, but were cured with simple remedies when hospitalized. In any severe case, hospitalization should be urged.

ECZEMATOUS FUNGUS INFECTION

This form of infantile eczema is not frequently seen. It usually involves the inguinal and gluteal folds. These infections are usually characterized by sharp margination. They are not vesicular, but weeping can be present. The color generally is a deep red. There is usually peripheral exfoliation. The central portion shows maceration of the superficial layers of the epidermis. Fissuring is common along the lines of the folds. The offending organism is easily identified in the scrapings.

These cases usually respond well to treatment. Local therapy consists of a powder or a simple lotion such as calamine lotion, N. F. or a starch lotion. A paste, such as Lassar's in which there is incorporated a 1 or 2 per cent ammoniated mercury, is useful in the drier forms. Gentian violet, 2 per cent in aqueous solution, painted on the areas once or twice a day, is often efficacious in the monial types of infection.

Prescription I. Mild antiseptic dusting powder

Powdered boric acid, zinc oxid, purified talc., each in sufficient quantity to make 30 grams.
Mix and dispense in sifter-top can.
Label: Use freely as required.

Prescription II. Antipruritic starch lotion

Phenol	0.25 to 1.0 per cent
Liq. Carbonis detergens (Wright's)	5.0 to 10.0 per cent
Zinc oxid	48.0 grams
Starch	48.0 grams
Glycerin	24.0 grams
Liquor aquae calcis.....	Sufficient to make 240 grams

Particular attention should be paid to the diapers. They should be boiled, and the last rinse should be a mild antiseptic solution, such as boric acid or a very weak solution of bichlorid of mercury. Rubber pants should not be used.

Fungous infections due to the trichophyton group, when occurring on trunk or extremities, usually are well treated with about half or quarter strength Whitfield's ointment. Another excellent remedy for this type of infection is an ointment containing 2 per cent sulphur and 2 per cent salicylic acid in petrolatum.

SEBORRHEIC DERMATITIS

This type occurs on the scalp, cheeks and, less frequently, the axillae and inguinal folds. It is made up of inflammatory patches with a considerable amount of scale, which has a greasy, yellowish appearance. It is most marked on the scalp. This is seen most frequently in babies who are overweight, and reduction in weight is of considerable help in treatment. The first step is to remove the scales. This is done by gently rubbing with gauze soaked in olive oil. This is the one form of eczema in which soap can be used in place of the oil to remove the crusts. After the scale has been removed, the area is dried and an ointment applied. Mild sulphur ointments, 1 to 3 per cent, are the most efficacious and have nearly a specific effect. Preparations having the same percentage of ammoniated mercury are also extremely useful.

CONTACT DERMATITIS

While this is the most common form of eczema in the adult, it does not present a great problem in infants. It should always be considered, however, and definitely ruled out before treatment is started. The eruption may be vesicular and is usually inflammatory and pruritic. There are ordinarily only one or two localized areas involved, and these most frequently occur on exposed surfaces. The first thing after the diagnosis is made is, of course, to remove the cause, as, for example, a dermatitis from a sweater. Wool and feathers, as has been shown by Osborn, are the most frequent cause of this type of eczema. Other substances, which should be excluded from the environment, are silk, kapok, pyrethrum, soap, and mercury in its various forms. Osborn feels that this latter is frequently the cause of hypersensitivity in infants. This develops early from the use of baby oils having mercury as the antiseptic. If the external irritation is found and removed, treatment is simple, as most of these eruptions will involute rapidly. In the weeping and vesicular stage, compresses of a saturated boric acid solution or Burow's solution

(liquor aluminum acetate, diluted 1-8; 1-15) are of value. A soothing lotion, such as calamine, is frequently all that is necessary. A paste, such as Lassar's, with a quarter to a half per cent of phenol for its antipruritic effect, is of value.

ATOPIC DERMATITIS

This is the classical form of infantile eczema. The face and flexor surfaces of the extremities are the sites of predilection. It is characterized by weeping, crusting, lichenification, and extreme pruritus. It is in this form that the diet is of particular importance, as will be brought out by others in this symposium. External irritants, such as feathers and wool, also play an important rôle, as in the contact type. For the weeping and crusting stage, the method of choice is compressing or applying massive wet dressings. Treating large areas is best done in the hospital. A few layers of moist gauze or cotton is not a wet dressing, because the exudate will stick to it and irritate the area and when it dries it does more harm than good. The dressings should be made from unstarched gauze or soft linen, saturated with the solution to be used and wrung out so that it is not dripping. This is placed on the affected areas, and should be at least two inches thick. The dressing is then covered with some sort of impermeable material, such as cellophane, to keep the dressings from drying. A dry bandage or towel is then put on to hold the dressing in place. To put such a dressing on the face requires considerable nursing skill. When improperly applied, a wet dressing is worse than none. Dressings should be changed every three to four hours. A wet dressing can be made with saturated boric acid solution, Burrow's solution 1-8, 1-20; potassium permanganate 1-5000 is an excellent solution if any secondary infection is present. After weeping and crusting have subsided, which should be in a few days, ointments are in order.

By far the most useful single remedy is crude coal-tar. One should make sure that eastern crude coal-tar is being used, and details should be given to the pharmacist if he does not know how to make the preparation. It should be smooth and dry. If it is not properly prepared, it crumbles and tends to aggravate the skin. Its proper preparation is with equal parts of crude coal-tar and zinc oxid mixed together. Then starch and petrolatum are mixed. These two mixtures are then worked in together to form a smooth black paste. This is applied gently to the affected areas, if there is any weeping and erythema present. If the areas are lichenified, the ointment should be rubbed in.

Prescription III. Crude coal-tar ointment

Crude coal-tar.....	4.0 grams
Zinc oxid	4.0 grams
Mix and add	
Starch	30.0 grams
Petrolatum	30.0 grams

Mix and label: Apply to affected areas two or three times a day.

Crude coal-tar can be used in full strength, the liquid being painted on the affected areas every other day. After the affected areas begin to show slight exfoliation, the tar should be stopped, and a simple paste of equal parts of boric acid ointment and Lassar's paste should be used. If the tar is used too long a dermatitis may develop. This is frequently of a follicular type. Another preparation which has been useful in my hands is a 10 per cent ichthyol incorporated in Lassar's paste. This is less irritating than crude coal tar. Naftalan, a mild tar used in 5 to 10 per cent strength, has the same indications as ichthyol.

COMMENT

No attempt has been made to include all the various remedies that are of value in the different types of infantile eczema. One treating these cases should become completely familiar with the medications he is using, so that the changing of only one or two per cent of any one ingredient in the course of the disease will mean involution, and not evolution, of the process. There are a few general statements that may be made:

1. Change of environment (hospitalization) is beneficial.
2. Removal of wool and feathers as common cause of contact reactions should always be done.
3. Dermatitis from local medication should be watched for. Mercury is the worst offender.
4. Weeping areas should be treated with wet dressings or compresses before lotions and ointments are used.
5. On inflamed areas, pastes are better than greasy ointments.
6. Recurrences are frequent, some unexplainable and others due to carelessness in following detailed directions.
7. Always remember that great majority of infants clear around the age of two years.

411 Thirtieth Street.

EPILEPSY*

A GENERAL SURVEY OF THE CONVULSIVE STATE

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CONVULSIONS occur in a truly bewildering variety of conditions. Paresis, brain tumor, diabetes, alcoholism, brain trauma, hysteria, uremia, and tetanus are but a few of fifty or more organic, toxic and functional disorders associated with convulsive manifestations.

Because of the mystery surrounding its etiology, the title of idiopathic epilepsy was given to a group of so-called spontaneous seizures; but just as fever and pain are symptoms of an underlying pathology, so should the epilepsies, or convulsive states, be considered.

The finding of neolithic skulls, with trephine openings to allow of the escape of the devils caus-

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ing epilepsy, antedating the written records of man, speaks for the antiquity of the disease. In the United States today, with an estimated 600,000 persons suffering from convulsive disorders and with over 40,000 of these confined in state psychiatric institutions,¹ it still remains one of the great social and economic problems.

In the state hospitals of California last year there were 22,608 patients.² Of these, 665 were epileptics whose yearly cost has been estimated at \$151,620. During the year, one hundred new cases of epilepsy were admitted. Of these patients, none had received a collegiate education, only eighteen had gone through high school, and 48 per cent were entirely dependent. There were thirty-six deaths among the epileptics and of these twenty had been in the hospital for an average of twelve and one-half years. These figures give but a small idea of the seriousness of the situation.

Those suffering from convulsive disorders and yet not hospitalized still remain a handicapped group. As automobile operators they are a serious problem, and their choice of occupation is necessarily limited, inasmuch as their sudden seizures cause a hazard both to themselves and to others. In large colonies these people do quite well together. At Agnew a practice is made to have male epileptics work on the lawns in groups of twos and threes. If one falls during a seizure, he has a soft carpet on which to fall, and the other patients in the group care for him until he is again ready to carry on. In this way they may even take trips into the country.

DIAGNOSIS

The diagnosis of epilepsy in a state hospital case is usually not difficult. In its incipency, however, this may be fraught with much uncertainty. Fainting spells, with convulsive movements, may resemble epilepsy very closely. Indeed sleep, faints, syncope, convulsions, petit and grand mal epilepsy, all have a strikingly similar underlying mechanism.

To elaborate further: sleep, as pointed out by Rosett,³ does not occur all at once but step by step through the sensory, associative, and motor fields. Thus, as one lies down to sleep the body is no longer in need of vestibular help to maintain equilibrium, visual stimuli cease, and auditory sensations are cut to a minimum. This allows the associative and thalamic fields to fill the mind with vivid and inaccurate memory images. As these fade, the motor area, at first active, next recedes, and the individual becomes, as it were, decerebrated. It is often possible at this stage to obtain a positive Babinski, and it is here that the familiar jerking movements are so apt to occur. Next the muscles become flaccid, no deep reflexes are obtained, the last neuron pathway through the stem and cord is closed, and the individual passes into a profound stage of sleep. Awakening proceeds in the reverse order.

STAGES OF AN EPILEPTIC SEIZURE

The various stages of an epileptic seizure can, according to Rosett,³ be closely correlated with those of sleep. Thus, a typical seizure is frequently ushered in by an aura with an accompanying narrowing of the sensory fields. One patient, E. S.,

described this aura to me as follows: "I feel funny, things seem to be floating before me, it's like looking through a fog. I seem to be reaching out for something, and then falling into space, dark space."

Following this suppression of the sensory field, associative and thalamic release next ensues, bringing with it vivid imagery and hallucinations, with an increased feeling tone. Patient G. V. explained the sensory aura to me as follows: "I can tell when it is coming; I feel ill in the pit of my stomach and a hot feeling comes in my left ear." Then follow hallucinations of hearing with a feeling of fear, as she puts it: "I get afraid and have a feeling that men are coming up from behind to grab me, and I can hear them say: 'Come on, we are going to get you.'" The patient next becomes unconscious as the wave passes on, and with the loss of the cerebrocerebellar pathway there ensues a state of tense muscular rigidity known as the tonic phase of the convulsion. Following this comes the jerking clonic convulsive movements of the whole body. At about the time these generalized convulsions are over, it is frequently possible to obtain a positive Babinski, indicating that the corticospinal pathway through the pyramidal tract has been extinguished. Following the convulsion, the muscles lose their tonicity and become flaccid, showing again that the last and most fundamental pathway of stem and cord has been blocked out. Recovery, as in sleep, proceeds in the reverse order: First, the muscles regain their tone, movements take place, dreams are common, and the patient, though at first confused, regains his usual conscious state once more.

This wave of disability may recede at any stage of the seizure and cause the syndrome to be only partially completed.³ Thus one may have only the preliminary aura without further trouble, or it may go on to a momentary loss of consciousness without proceeding to the convulsive stage. Thus patient A. Z. came to my office one day and, in a somewhat euphoric mood, began telling me how long it had been since he had had a convulsion. "Doctor," he said, "it's been at least six months since I've had a spell, yes, sir, at least six months." Suddenly, with a far-away look in his eyes, he turned, walked to the corner of the room, picked up a feather duster and, holding it before him as he would a candle, made a tour of the room as if looking for some lost object. Then, replacing the duster in the corner he came back, and as he focused his gaze on me once more, continued: "Yes, doctor, it's been all of six months since I've had a spell." He had, of course, just experienced an epileptic equivalent of which he himself had no appreciation.

OTHER PHASES

As stated above, faints are often accompanied by convulsive movements, and are hard to distinguish from light attacks of epilepsy. Fainting is often preceded by the feeling that everything in the environment is floating away. Daylight seems to be a long way off and, finally, complete blackness ensues. Gowers cites several cases in which fainting attacks eventually developed into true epilepsy.⁴

It is interesting and significant to note that dizziness, syncope, and fainting can be caused by pres-

sure on the carotid sinus. It is also suggestive that, by exerting more and more pressure on the sinus, convulsions can be produced. The symptoms caused by this pressure, according to Smith,⁵ are aura with spots before the eyes, epigastric distress, light-headedness, unconsciousness, and mild convulsions—the typical syndrome of epilepsy. According to Weiss,⁶ in some cases carotid pressure causes a slowing of the heart and a lowering of the blood pressure. In other cases it neither lowers the blood pressure nor slows the heart, but acts directly on some brain center, probably producing a sudden change in the cerebral vessels, consisting of a contraction followed by dilatation, thus accounting for the syndrome. The occurrence of dizzy spells, fainting spells, and generalized convulsions were found in 16 per cent of a series of one hundred consecutive cases of senile and arteriosclerotic psychosis, as reported by Tompkins.⁷ Of these, 6 per cent were of the epileptoid character, 7 per cent were convulsive, and 3 per cent showed a profound and lasting change in consciousness. It would be hard to believe that these dizzy spells, faints, and convulsions were not all an integral part of the convulsive state.

Convulsions can likewise be produced by drugs, such as insulin and metrazol, which are used extensively in the shock therapy of schizophrenia. These convulsions resemble epileptic seizures and can, of course, precipitate attacks in those suffering from epilepsy.

COMMENT

Great progress has been achieved in brain surgery through the use of delicate electrodes in producing convulsions by spotting the aural center which sets off the convulsive explosions, but much argument has arisen as to what course these convulsion-producing waves pursue. Penfield⁸ likens the condition to a cyclone, which sweeps through the brain, causing wild, uncoordinated muscular contractions.

Recently, however, Erickson⁹ has demonstrated quite convincingly that, in monkeys, convulsion-producing waves follow along the motor convolution from one contiguous area to the next, probably by means of the short intracortical association fibers. When this wave—*e. g.*, one passing up the convolution from the arm to the leg area—is interrupted by a transverse ligature, it does not jump the gap and continue up to the foot center, but crosses by way of association fibers through the corpus callosum to the corresponding arm area of the opposite hemisphere. Here it continues a course up this convolution to the leg center, where it recrosses above the ligature and into the leg area of the original hemisphere.

This theory of the progression of waves would seem to apply to the sensory as well as the motor area if the description of an aura, as given by my patient B. B., is correct. She stated that she first noticed a numbness arising in the toes of the left foot. This numbness proceeded up the leg into the thigh, along a narrow band from the thigh to the left shoulder, thence down the arm and out into the fingertips of the left hand. (This patient was left-handed.) It will be noted that this description

follows in sequence the contiguous sensory areas as mapped out by cerebral experimentation. Occasionally, this patient said, when the sensation reached the left hand there followed almost simultaneously a feeling of numbness in the right hand. Efforts had been made by teachers to make this left-handed individual right-handed. This suggests that a deepened pathway through the corpus callosum might account for the occasional crossing of the aural wave from the left to the right hand.

The fact that so many seizures occur at night would also suggest that, through sleep and the abeyance of the sensory field, the first step in the neuron arc toward the convulsive explosion has already been taken. The powder seems to lie somewhere along the associative, thalamic, or motor pathway. It might even reside in some localized irritative lesion of the sensory area, where it remains ready to be set off by the constant pulling of this trigger.

Why these waves should start, no one as yet knows. Starr¹⁰ cites the case of a young girl who was suddenly awakened at night by her brother, who had covered himself with a white sheet. She was much alarmed and one hour later had a major attack. Following this she became a confirmed epileptic. Fright was given as the cause in this case, yet the fact remains that ordinarily no one would develop epilepsy from such a fright. However, it might have been the precipitating factor in a subject potentially an epileptic. Such seems to have been the case in a diminutive-sized schoolgirl, M. R., whom I saw playing a trombone in an orchestra. At the end of a long number in which she had played a trombone solo, leading up to the grand finale, she gave a last supreme blast. As she did so, she fell from her chair with a cry and experienced a generalized convulsion. The hyperventilation in a potential epileptic had done its work. To date, seven years later, she has had no further trouble.

Recent work in electro-encephalography tends to show that this convulsive potentiality is present in certain individuals, and indications are that this type of work will be of great help in the understanding and prevention of these convulsive disorders.

The most noteworthy advance in recent medical therapy is the discovery of dilantin sodium which, unlike most drugs, does not produce drowsiness, but at the same time is most effective in reducing the number of seizures.¹¹

SUMMARY

In this survey of the convulsive states, the following points have been emphasized:

1. The economic and social importance of caring for 600,000 epileptics.
2. The similarity in the fundamental mechanism of the convulsive state with sleep, faints and syncope, as evidenced by carotid pressure, cortical stimulation, and clinical manifestations.
3. The momentous aid given by modern research to the understanding of these convulsive disorders.

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THE INTERPRETATION OF LABORATORY EXAMINATIONS IN THE DIAGNOSIS OF INFECTIOUS DISEASES*

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PART II†

ANOTHER type of infection that may be extremely acute and accompanied by vegetative endocarditis, which may give no murmurs, is that resulting from hemolytic streptococcal infection. The following case is an example.

A man, 44 years of age, develops fever, abdominal pain, and diarrhea, followed by jaundice, hematuria, nitrogen retention, and Streptococcus hemolyticus bacteremia. Death in ten days with acute bacterial endocarditis and focal embolic nephritis.

CASE 4.—This patient was in excellent health until four days before admission to the hospital. At that time he developed nausea and vomiting and shortly thereafter had abdominal cramps. The following day he had frequent loose bowel movements. The vomiting, abdominal cramps and diarrhea increased in severity until the time of admission. He also complained of chilliness and sweats, which appeared off and on for two days before admission.

Examination showed a well-developed individual who appeared acutely ill. He was mentally clear and cooperative. His temperature was 102 degrees Fahrenheit, pulse rate 110, blood pressure 120/60. Examination of the head, nose and throat proved negative. The heart and lungs were clear throughout. There were no cardiac murmurs. The abdomen showed slight tenderness over the upper half, but no masses were felt and the spleen was not palpable. The

extremities showed an amputation stump of the left leg below the knee. Rectal examination was negative.

Urine examination showed no albumin, one or two white blood cells, and rare erythrocytes. The red blood cell count was 4,500,000, hemoglobin 81 per cent, white blood cell count 14,300. Nonprotein nitrogen was 50 milligrams per 100 cubic centimeters.

The clinical course in the hospital was one of progressive failure, the temperature varying between normal and 100 degrees Fahrenheit. On the fourth day after admission to the hospital, the seventh day of his illness, he became deeply jaundiced and the icteric index was recorded as 100 units. At the same time there was a progressive increase in his nitrogen retention. The urine contained no albumin, only a few white blood cells and red blood cells. On the fifth day the jaundice was increasing and the patient developed gross hematuria. The liver edge was felt two fingerbreadths below the costal margin; it was smooth but not especially tender. No murmurs appeared over the heart. Blood cultures, taken on the seventh, eighth and ninth days, showed hemolytic streptococci.

The clinical course, then, was that of a man who had been perfectly well until nine days before his death, when he was seized with abdominal pain, nausea and vomiting, and diarrhea. This was followed by fever, the development of jaundice, and the appearance of hematuria, with hemolytic streptococci in the circulating blood. Necropsy showed acute vegetative endocarditis of the aortic, mitral, and pulmonic valves and acute bronchopneumonia. In brief, this was an instance of hemolytic streptococcal sepsis with jaundice and vegetative endocarditis, focal embolic nephritis, and renal insufficiency. The nonprotein nitrogen of the blood increased from 50 to 188 milligrams per 100 cubic centimeters between the first and the seventh day of his illness. Here again is an instance of infection with bacteremia in which it was not possible to discover the primary focus or portal of entry. The course was extremely acute and produced lesions on the heart valves, which had not progressed to the stage where the leaflets were destroyed but were large enough to give origin to numerous emboli which went to the kidneys and produced a focal glomerular nephritis. The diagnosis of streptococcal infection during life would not have been made without blood culture.

The above cases illustrate how bacteremia aids one in making an etiologic diagnosis of an otherwise obscure infection. Blood cultures may also provide one with information when there is a mixed infection, such as is illustrated by the following case.

A common problem in diagnosis is the explanation of fever which recurs following a pneumococcal lobar pneumonia. While the possibilities must include the search for focal infections, i. e., empyema, endocarditis, or meningitis, very often there is an infection due to another organism, such as a hemolytic streptococcus, and the diagnosis is made by culturing the blood and examining the pleural fluid or sputum. Such cases, of which the following is an example, have been reported by Parsons and Myers,¹⁰ Finland,¹¹ and Curphey and Solomon.¹²

A young man with pneumococcus Type I pneumonia and bacteremia fails to respond to large amounts of specific serum. Sputum contains large

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numbers of hemolytic streptococci, as well as pneumococci. Blood culture later becomes positive for hemolytic streptococcus.

CASE 5.—This man was admitted to the hospital with the classical signs of lobar pneumonia due to Type I pneumococci with bacteremia. In spite of the administration of large amounts of antipneumococcus horse serum, the temperature did not return to normal, as is customary in most cases of Type I pneumococcus infection treated with serum. Re-examination of his sputum showed that the patient had a mixed infection, since the pneumococci were accompanied by large numbers of hemolytic streptococci. On the eleventh day of his illness there were signs of a mediastinal pericarditis with a loud friction rub, which was synchronous with the heart beat and was exaggerated by respiration. On the thirteenth day of his illness hoarseness developed and he was unable to speak above a whisper. On the following day he had pain under the gladiolus and difficulty in swallowing. He died on the seventeenth day of his illness. The results of culture of the blood, beginning on the fourteenth day, showed that he had numerous colonies of hemolytic streptococci in the circulating blood. Necropsy showed a resolving pneumonia of the right lung with many abscesses, diffuse mediastinitis, and empyema (hemolytic streptococcus) on the right side in the anterior mediastinal pleural space.

This case, information about which was obtained only by careful examination of the sputum and repeated blood cultures, emphasizes the importance of recognizing mixed infections as a cause of pneumonia.

THE SIGNIFICANCE OF NEGATIVE BLOOD CULTURES

When there are symptoms and signs of an infection without bacteremia, the following interpretations can be placed on this finding: (1) that one is dealing with an infection not due to a pyogenic organism; (2) that the infection is localized, and the defense mechanism of the body is adequate to prevent an invasion of the blood; or (3) that the infection is caused by an anaerobic organism.

For example, it is infrequent to find bacteremia in mastoiditis, tonsillitis, pyelonephritis, or pylephlebitis, and when any of these diseases are associated with bacteremia it usually means an extension of the process to the neighboring veins or a rupture of the local defense mechanism. In about 20 per cent of cases of bacterial endocarditis, the blood cultures are persistently negative, and there is evidence from a study of these cases that the organisms fail to grow, not because of faulty technique but because of the presence of a high titre of immune bodies in the circulating blood.

In any case in which the symptoms of a pyogenic infection are present without bacteremia, it is highly suggestive of a localized infection with a defense mechanism that is adequate to localize the infection, but that may be inadequate for complete sterilization of the focus.

AGGLUTINATION TESTS

Specific serological reactions in the blood are of the greatest aid in the diagnosis of infections which do not produce bacteremia. They are a definite sign of an immune response to the infecting organism. Repeated examinations are of greater significance than an isolated observation, since an increasing titre is the rule in an active infection, whereas a low, stationary titre must be assessed with greater

judgment. In general, it can be said that a positive agglutination reaction in the blood indicates previous experience with that group of organisms and, in many cases, it is a sign of an active infection. Agglutination reactions are of the highest value in the diagnosis of the enteric infections (Eberthella, Salmonella, and dysentery infections), in undulant fever, tularemia, rickettsial disease, and in the diagnosis of glandular fever.

Concerning agglutination tests in general, one may say that they must be interpreted in the light of clinical features of the disease. Positive reactions mean either previous experience with the organism or an active infection. If the titre of agglutinins increases during the period of observation, then the diagnosis of an active infection is almost certain. If it is low and remains stationary, then its significance, in so far as diagnosis is concerned, is less certain.

In regard to Widal examinations, the following general rules are helpful:

1. Agglutinins for typhoid bacilli in a titre above 1:40 are rarely, if ever, found in the serum of individuals who have not been vaccinated or who have not had typhoid fever in the past.

2. Many laboratories now report the results of H (flagellar), O (somatic) and Vi (somatic-virulent) antibody titres in their Widal tests. From a single agglutination test one may be reasonably safe in making a diagnosis of typhoid fever, if there is a high titre (1:250 or higher) of H agglutinins in an uninoculated person, or a titre of 1:1000 in a person who has not been inoculated recently, or an O titre above 1:250 in the uninoculated or not very recently inoculated.

During the course of typhoid fever an individual may develop no H agglutinins while developing O agglutinins. For this reason it is always advisable to carry out the tests with both antigens.

When an individual with the clinical picture and course of enteric fever fails to develop antibodies, it may be due to one of the following reasons: (1) he may have some other disease; (2) the test was carried out too early in the course of the disease; or, (3) the proper antigen was not used—an insufficient number of strains were included in the tests to detect agglutinins against organisms which are capable of producing enteric fever.

Melitensis Agglutination Tests

In the interpretation of these tests, the following points are significant:

1. A negative agglutination test does not exclude B. abortus or melitensis infection.

2. A positive agglutination test, regardless of the titre, means previous experience with this organism. When the titre is above 1:80, it generally means an active infection.

3. It is always well to use high, as well as low dilutions of serum in order to eliminate the phenomena of prozone reactions; that is, positive agglutinations in high dilutions and no agglutination in low titres.

Tularemia Agglutination Tests

Positive reaction in dilutions of 1:80 or over are significant. The following points, however, must be considered:

1. There may be cross-reactions between *B. melitensis* and *B. tularensis*. When this occurs, the titre for *B. tularensis* usually increases in active infections and the *melitensis* agglutinins remain stationary.

2. Specific agglutinins are usually absent during the first week of the disease and become positive during the second week; but they may be delayed in their appearance as long as the third week.

3. The maximum titre is often reached in the third week and remains high for four to seven weeks and then declines. It rarely disappears entirely and may be positive for as long as twenty-five years.

Dysentery Agglutination Tests

This test is valuable in the diagnosis of dysentery when organisms can not be isolated from the stools. When formalinized cultures are used, an agglutinin titre of the serum of 1:25 and 1:40 is suggestive of the presence of an active infection. A number of different strains should be used in the tests.

Proteus OX19 and OX2

Positive agglutination reactions for *Proteus* OX19, OX2, and OXK are important in the diagnosis of the various rickettsial diseases, especially in endemic typhus and the group causing Rocky Mountain spotted fever. Titres of 1:80 or 1:160 are significant.

The following cases illustrate the value of agglutination tests in diagnosis.

It was stated previously that one occasionally encounters a patient who has all the symptoms and signs of enteric fever with negative Widal examination and blood culture. This may be explained, in part, by failure to use the proper antigens in studying the blood for specific agglutinins, as shown by an example of such a case.

A man with the clinical picture and features of enteric fever has negative blood cultures and agglutination reactions against typhoid and paratyphoid B organisms. Positive agglutination reaction for B. aertrycke.

CASE 6.—A young, mechanical engineer, 27 years old, was admitted to the hospital in a confused and mentally cloudy state. He was irrational, disoriented and extremely ill. He was unable to give a history of himself but from members of his family it was learned that two weeks before admission there was a sudden departure from health, symptoms of an infection, and slight diarrhea. Within four days he had high fever, diarrhea and vomiting, which continued up until the time of admission to the hospital. It was stated that he had received typhoid inoculation on two occasions in the past; the first time eight years before admission and the second two years. He had been exposed to unsanitary conditions due to work in an area where floods had recently been prevalent.

Examination showed a young man who was acutely ill, disoriented and irrational. Tongue was dry and coated, the lips were parched, the skin was hot and dry, and there

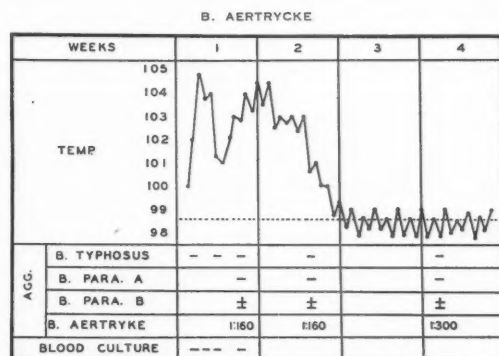


Fig. 3.—(Case 6) Chart showing temperature curve and results of agglutination reactions and blood cultures in a patient with enteric fever due to *B. aertrycke* infection.

was slight icterus of the sclerae. Scattered over the skin of the trunk and, to a lesser extent, on the arms and legs were numerous pink macular to maculo-papular areas ranging in size from 2 to 4 millimeters in diameter, which blanched on pressure. The head, neck, heart and lungs revealed nothing abnormal. The abdomen was moderately distended, the spleen was easily palpable 3 centimeters below the left costal margin in the midclavicular line, and the liver was not felt. Rectal examination was negative.

The urine examination showed a trace of albumin, a small amount of bile pigment and acetone. The sediment had an occasional cast, with an increase in the number of white blood cells. The urine was concentrated. The white blood cell count was 7,050, with an essentially normal differential count. Stools were soft, semi-solid, and contained a small amount of occult blood. Blood culture on admission was negative, as were agglutination reactions against typhoid, paratyphoid A and B, *B. melitensis*, and Weil-Felix reaction. The cultures on the urine and stools, which were made three days before admission to the hospital, were likewise negative for the enteric group of organisms.

Repeated stool cultures showed, on one occasion, gram-negative organism having the sugar fermentation of bacilli falling into the salmonella group. When *B. aertrycke* were included in the antigen for the Widal test, it was found that they were agglutinated in a titre of 1:160. This was repeated on several occasions.

The course of the patient's temperature is seen in the accompanying chart (Fig. 3). The clinical course was characteristic of enteric fever, but the absence of bacteremia and the negative Widal examination with the common organisms usually causing enteric fever was somewhat confusing. When the *aertrycke* were included in the antigen used for Widal examination, they were then found to be positive. The course was uneventful and the patient made a complete recovery.

Unless the *B. aertrycke* organisms had been included in the antigens used for carrying out the Widal tests, the etiology of this particular case of enteric fever would never have been determined.

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(To be concluded)

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CLINICAL NOTES AND CASE REPORTS

INTRADERMAL TUBERCULIN: PARENTAL REASONS FOR REFUSING

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THE mass testing for tuberculosis of adolescents and young adults as carried on in Los Angeles high schools must begin by obtaining parental consent for the test. Contact of the school with the parent is for the most part indirect; by word of mouth through the student, and by letter and questionnaire addressed to the parent. But whatever the approach to the parent, we come far from winning universal consent for the test; 60 to 70 per cent of the school enrollment is a good average.

REASONS ADVANCED FOR REFUSALS

With the thought of ascertaining the basis of parental refusal of the test, we included in the case of a few schools, as an item to the questionnaire, the sentence, "If you refuse the tuberculin test, kindly state why?" In about one-third of the returned questionnaires, this request for information was ignored. The refusals available for study numbered 1,432.

Statistical study of this material was made by Mr. Herbert Sauer of the Los Angeles Tuberculosis and Health Association, one of the cooperating agencies in this case-finding project; and some of the figures are shown below, based on 1,432 replies:

Reason	Per Cent
Not necessary.....	28.7
Private physician.....	27.0
Previous tuberculosis examination.....	13.6
Belief, religious.....	14.5
Belief, secular and not specified.....	12.0
Other reasons.....	4.2

The most common reason for refusal, 28.7 per cent, was the belief that the test was not necessary: "Has always been healthy," "A sturdy, strong child," "No chance to get tuberculosis," etc., being typical replies. We must accept this situation as a challenge to the adequacy of health education among the populace. Over 90 per cent of the enrollment of these schools is made up of white children, and most of the schools concerned are located in the "best" areas of the city. Yet about 29 per cent of these parents have not grasped the fundamental facts that, first, exposure to tuberculosis is virtually inevitable, and, second, early tuberculosis may give no symptoms whatever and produce no signs.

Almost as large a group, 27 per cent, gave as a reason for their refusal, that all health problems were entrusted to their physicians: "Leave such matters to our doctor," "My doctor attends to these things," "Our physician has apparently not felt it necessary," etc. To the extent that the physician in private practice believes that the routine case-finding program is advisable, the en-

trusting of such confidence on the part of the parents would seem to be a challenge to him, and this 27 per cent of refusals, as a measure of his neglected opportunities. But this overstates the case. Busy or indifferent parents, unwilling to bother with thinking the situation through, have undoubtedly given this reply as an "escape" or as a rationalization of their *laissez faire* attitude toward health matters, which does in truth account for their negative action. Based on the few cases which we followed up, we may state that it was rare indeed for the parents even to have telephoned their physicians concerning the matter of the proposed skin tests.

About 15 per cent of the refusals were due to religious beliefs. This group, at the present time at least, may be considered as a fixed segment of resistance to public health progress not open, in a school program, to approach.

Almost an equal number, 12 per cent, expressed, as the basis of refusal, contrary beliefs of a more secular character, such as: "Against belief," "Do not approve," "Do not believe in test," "Opposed to injections and serums," etc. Many of this group, like the first mentioned, only await enlightenment to become more cooperative, and are ready to listen if they can be reached.

Of the previously tested 13.6 per cent, the great majority had already been given, but some had been tested by private physicians and clinics in various parts of the country.

COMMENT

No phase of the general tuberculosis control program in our country has been more rapidly expanded during the past decade than mass testing among the schools. No other device can so easily bring to light the minimal cases among young persons and, where a proper epidemiologic follow-up is carried on, lead so directly to heretofore unsuspected sources of infection.

It appears from the data presented above that the chief barrier to the universal success of this program is the lack of understanding on the part of the public concerning the nature of tuberculosis disease. Yet many agencies are deeply and actively engaged in health education aimed to create this understanding. The schools themselves already figure large in this program, and every "Life Science" course presents innumerable opportunities to direct the students thinking toward health matters in some measure. As evidence that such opportunity is not being entirely wasted, we may cite the results of a small survey made at one school (the Los Angeles High) where 63 per cent of students in Life Science classes took the test compared with 52 per cent of the entire student body. However, among the 37 per cent of those Life Science students who did not take the test, the reasons given by the students for not doing so show that they themselves entertained essentially the same false beliefs as did the parents who refused permission.

Undoubtedly, physicians have in the past hesitated to offer the intradermal skin test with subse-

quent chest x-ray of the positive reactors to healthy young persons, fearing that such action might be interpreted as exploitation. We shall do well to keep in mind, however, the widespread activities in public health education now being carried on among the people, and to realize that our clientele is rapidly being made ready to accept this service when it is offered by their family doctor.

We have no one to thank but ourselves if we allow the tuberculosis test to become almost the accepted field of public health agencies, as we have already done in the case of smallpox and diphtheria immunization. In the meantime, those among us whose clientele is unable to pay for this service can vastly increase the effectiveness of these important preventive measures by explaining the basis and justification of the test as carried on by public health agencies.

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TUBERCULOSIS IS WHERE YOU FIND IT

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EVER since Laennec discovered auscultation, physicians have been listening for adventitious sounds in the chest. Hearing none and eliciting no other abnormal findings, they have concluded that no pathological condition of the chest existed. This teaching has persisted through years so that unless a patient presented himself with most of the classical symptoms and signs of tuberculosis, too often his chest was dismissed as negative.

Not so many years ago the disease tuberculosis ranked first among all causes of death in this country. In 1900 the mortality from this condition was 202 per 100,000. Since that time the picture has changed considerably and today this disease has descended to seventh place among causes of death; by 1938 the mortality rate from it having dropped from 202 down to 48.6 per 100,000.

Many factors have contributed to this improvement, such as better treatment, public education, improved diagnostic measures; and, hence, earlier diagnosis, case-finding methods, and finally the realization on the part of the physician that tuberculosis may be active in a patient without the classical picture of "consumption."

Indeed, this is probably one of the most important truths that has dawned upon our medical consciousness: tuberculosis may be active and progressing without any signs or symptoms of it being apparent to the patient or to the physician making an ordinary examination.

To illustrate this, the following cases are offered.

REPORT OF CASES

CASE 1.—I. S. Age, 21. This patient worked as a beauty operator near a university campus and all of her clients were college girls. She felt fine, never was overtired; had no cough nor any other symptoms of illness.

One night in July 1937, however, she coughed a little bit and noticed some blood streaks on the sputum. Her mother became alarmed and sent her to the family physician, who had a chest x-ray taken. This revealed a cavity in the right upper lobe about one-half inch in diameter, with an area of infiltration around it. (Fig. 1.)

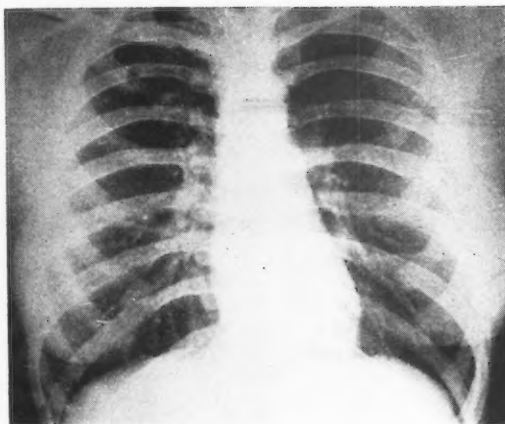


Fig. 1.—Showing small cavity in right upper lobe.

Her tuberculin test was found positive; she was hospitalized and her pneumothorax started. Today the cavity is closed, and she is receiving her pneumothorax treatments regularly and is back at her old job. She had felt perfectly well until blood appeared when she coughed.

The next step after making the diagnosis on this patient was to check her contacts; those people about her who might be infected. There were four members of her family, and they were all tuberculin-tested and fluoroscoped. Each was found to be negative until her younger sister was examined.

The sister was a very athletic girl of nineteen. She was a star basketball player and girls' yell leader in her high school. She had never known a day of illness and was the picture of good health and energy. She was examined and no physical signs of disease could be found. However, when she was fluoroscoped, an area of infiltration was found in her right upper lobe just below the clavicle. Her tuberculin test was positive and she was hospitalized and her treatment started.

Today she is still feeling perfectly well, because she was examined as a contact and an early diagnosis of tuberculosis was made. She, too, is back at work and is leading a very normal life.

COMMENT

Now these two cases present nothing unusual so far as pathology, clinical course or treatment are concerned. Their diagnosis was easy and their prognosis is good. They are presented to emphasize two points:

First, that a person may feel perfectly well and look fine, yet have active pulmonary tuberculosis.

Second, that all contacts to a case of active tuberculosis should have an adequate examination; at least a tuberculin test and then, if that is positive, some type of x-ray examination.

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LEIOMYOMA OF VAGINAL WALL

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AND

WILLIAM E. ROGERS, M. D.

Santa Rosa

SOLITARY leiomyomas of the vagina are uncommon tumors, yet may be of importance because of malignant transformation, local mechanical factors and the possibility of sepsis. While this instance does not illustrate any one of these points, it is of value from the statistical standpoint.

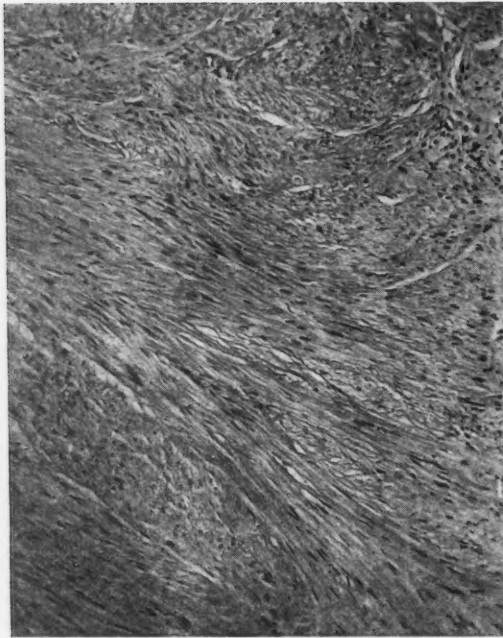


Fig. 1

Fig. 1.—Photomicrograph (120x) of section of tumor, showing cells which resemble smooth muscle cells. Note bundle of cells.

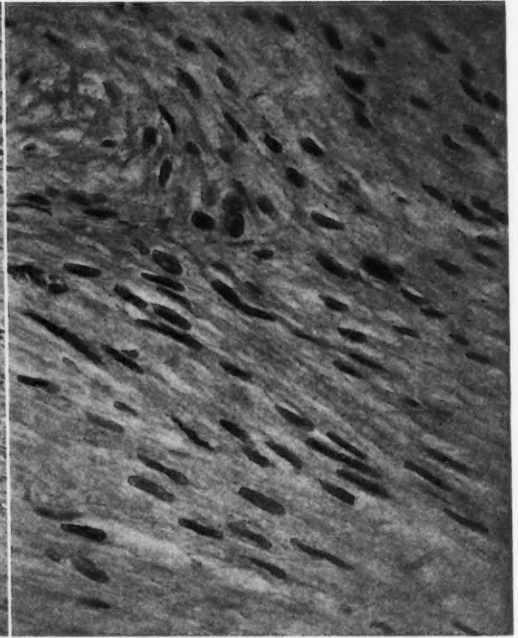


Fig. 2

Fig. 2.—Same (500x), to show nuclear structure.

REPORT OF CASE

CASE 1.—A white, married, nonparous female, aged 42, was first seen on October 10, 1939, at which time she complained of menorrhagia, metrorrhagia, pain in the left hip and knee, and frequency of urination. Eight years before she had been treated in a sanatorium for one year for pulmonary tuberculosis. Roentgen and physical examination of the chest on October 25, 1939, showed no sign of active tuberculosis. Seven years ago she had a left oophorectomy. A pelvic examination in October, 1939, revealed no changes in the uterus or adnexae. The vagina had well-marked rugae, but no tumor was demonstrated in the wall.

Laboratory Report.—Hemoglobin (Sahli), 78 per cent, 12.8 grams; red cell count, 3.90 per cmm.; white cell count, 6,000 per cmm.; differential count, normal; urinalysis, essentially negative.

Progress.—The patient was put on theelin, 5,000 units i.m., twice weekly, in the hope that the menorrhagia and metrorrhagia were due to ovarian dysfunction. Since she showed no response to these, a uterine curettement was done on November 13, 1939. The scrapings proved to be hyperplastic endometrium, without evidence of malignancy. At the time of operation, the vagina showed no abnormalities. After curettement her menstrual cycle returned to normal. Several pelvic examinations were made during the subsequent months, each of which revealed no abnormalities of the vagina. On March 29, 1940, a routine pelvic examination was done. At this time a small, pea-sized mass was found lying just beneath the vaginal mucosa in the left lateral wall at the inferior level of the cervix. The mass was nontender, moveable, and not attached to the underlying tissues. There was neither redness nor induration of the overlying mucosa.

On April 4, 1940, the patient was taken to surgery and, under novocain infiltration, a small hard tumor, including the overlying mucosa, was removed. It measured 1.5 by 1 cubic millimeter in the fresh state. It was white, solid, and noncystic.

Pathologic examination by Dr. David G. Mason of St. Luke's Hospital, San Francisco, revealed the following changes:

Gross Pathology.—An oval-shaped tumor, measuring .8 by .6 by .5 centimeters in diameter, is present. It is white,

solid, and on section is found to possess smooth, greyish-white surfaces. One block of this is used for a section. A piece of flat vaginal mucosa, measuring 2 by 1.5 centimeters, is also received.

Microscopic.—Microsections (photo 1 and 2) of this small nodule show it to be formed by well-differentiated, elongated cells resembling smooth muscle cells. These cells are arranged in broad bundles, seen both in the cross and longitudinal plane. There was little to no fibrous tissue present, as shown by the Van Gieson stain. There was no evidence of malignancy.

Pathologic Diagnosis.—Solitary leiomyoma of the vaginal wall.

On examination on July 10, 1940, three months after removal of the tumor, the wound was found to be well healed.

SUMMARY

An instance of uncomplicated leiomyoma of the vagina occurring in a 42-year-old woman is reported.

507 College Avenue.

STREPTOTHRIX OF THE LUNG*

REPORT OF CASE

By JULIUS ZELMAN, M. D.

Murphys

FUNGUS infections of the lung present diagnostic problems for the clinician as well as for the bacteriologist. Emphasis is placed on careful study of the patient, and the use of a method available for obtaining a satisfactory specimen for laboratory study. In this case report, a specimen obtained at bronchoscopy was invaluable in the diagnosis.

* From the Department of Public Health (San Francisco) Tuberculosis Service. Sidney J. Shipman, M. D., chief; Alfred Goldman, M. D., bronchoscopist.

Until 1932 only sixty-five cases had been published under the heading of "Streptothrix." Since then two cases have been made known by Kerlan.¹

In the San Francisco Hospital, in the period of July 1, 1919 to June 30, 1936 (fiscal years), 19 of 167,547 discharges were for fungous infection of actinomycosis or streptothrix group. Of these nineteen, only four had pulmonary involvement, and the diagnosis was made in three at autopsy. One was diagnosed as a bronchogenic carcinoma; one as a tuberculosis with an effusion; another an empyema of unknown origin, diagnosis made from pus recovered at operation; and the last was secondary to a skin lesion. In two of the above cases, the initial complaint was pleuritic pain, followed two to six months later by hemoptysis and a productive cough. An empyema was a complication in two cases and a retroperitoneal abscess in one. In all cases, repeated cultures of the sputum and pus were necessary before organisms were recovered.

REPORT OF CASE

B. C., white, male, aged 43, single, baker. Entered hospital on February 24, 1938.

History.—On January 1, 1938, patient noticed a swelling on his left hip, which became progressively larger with time. Associated with the above was loss of weight and weakness. He consulted a physician and entered a private hospital. Here the swelling was incised and allowed to drain. The patient remained in the above hospital three weeks, during which time the abscess continued to drain and a cough, productive of a purulent sputum, developed. He then entered the San Francisco Hospital, complaining of a draining left hip abscess, loss of fifteen pounds, deep, dull pain in right chest and shoulder on respiration, and a productive cough.

His past history was essentially negative, except that the patient lived in Bakersfield nine years prior to his San Francisco residence of two years.

His examination here showed a temperature swing of 99.0 to 100.0 degrees Fahrenheit, pulse of 85, and respiration 22. His skin and mucous membranes were pale and moist, mouth hygiene poor, and dyspnea was present on the least amount of exertion in bed. Chest signs were limited to the right side, with wasting and lag on respiration. Vocal fremitus was increased, dull to percussion, particularly to the base posteriorly. Expiratory note was prolonged and an area of egophony was present anteriorly to the fourth interspace. Subcrepitant râles were present over this area. Laboratory report showed: red blood cells, 3,800,000; hemoglobin, 80 per cent; white blood count, 7,800; polymorphonuclear, 70 per cent; lymphocytes, 25 per cent; monocytes, 4 per cent; eosinophils, 1 per cent; Wassermann and Kahn was negative. Sputum was negative for acid-fast organisms on direct smear. The x-ray report of February 26, 1938, read: "There is a retraction of the right rib cage, with displacement of the heart to the right and partial atelectasis of the lower lobe. The entire right lung shows an irregular infiltration. There is thickened pleura, and possibly a small amount of fluid in the pleural space. There are no changes about the left hip."

During the following month a biopsy of the sinus was taken, and a thoracentesis of the chest was performed. The thoracentesis resulted in a dry tap, and the report of the biopsy revealed nothing but chronic granulation tissue. On April 1, 1938, a bronchoscopy was performed, at which time smears and cultures were taken for laboratory diagnosis. On April 6, 1938, a coccidioides skin test was negative. By April 9, the patient developed a swelling in the midline of the neck over the thyroid cartilage. This hard swelling became fluctuant in four days and, although two attempts were made to aspirate fluid from the mass, no free fluid was obtainable. Three days later the mass broke

during the night and drained. Cultures from this drainage were negative, except that some yeast-like colonies were found.

On May 1, 1938, the patient developed a tender swelling in the right loin, unaccompanied by fever, chills or urinary complaints. On examination there was a brawny swelling in the right loin, occupying the whole space between the lower ribs and ilium, pointing anteriorly beneath the anterior abdominal wall, but not attached to it. The mass was tender, warm, and did not move with respiration, and its location suggested a perirenal relationship. The diagnosis at this time was against the usual pyogenic perinephritic abscess, because of the absence of fever, and was thought to be most likely a psoas abscess.

The x-ray examination of May 20, 1938, revealed a clearing of the process in the right lung, with the diaphragm markedly elevated. In view of these findings, a right psoas abscess, pointing into the flank with definite suppuration of an actinomycotic group, seemed likely. On June 3, 1938, the patient was operated on the flank.

He was placed with the right side up, and an incision paralleling the crest of the right ilium and down the wall muscles was made, and a large abscess cavity containing about 100 cubic centimeters of foul pus was opened. This cavity extended downward and upward as far as one could probe with the finger, and appeared to involve only the region of the stomach muscles. The peritoneum was not opened. Specimen of the pus was sent to the laboratory for diagnosis.

Drainage continued until August 20. All wounds, except the original sinus and the right lung, had cleared markedly by x-ray, cough had disappeared and the patient had gained fifteen pounds in weight.

On August 24, final laboratory report was obtained and showed that the organ isolated from the specimen obtained at bronchoscopy grew anaerobically in media to which blood had been inoculated. It was pleomorphic in character, nonacid-fast, and stained both Gram-negative and Gram-positive. Typical branching was seen. The organism obtained from culture was inoculated into a guinea pig, and the animal, at autopsy, failed to reveal any lesions.

COMMENT

This case presented a problem in diagnosis. After entry into the San Francisco Hospital the patient developed lesions in his neck and flank. Whether the lesions were metastatic or contiguous was not determined. However, it was interesting to us that as soon as the lesions were opened and drained, healing took place without sinus formation, suggesting an anaerobic character of the causative organism. The organism was atypical in form, but the culture characteristics were those of the actinomycosis group and more specifically of an anaerobic streptothrix.

We also point to the invaluable aid of the bronchoscope in obtaining uncontaminated specimens for culture.

Iodids were of no avail in therapy, but marked improvement seems to take place after thymol therapy. The patient was eventually discharged afebrile, sputum-free, and all sinuses closed.

Bret Harte Sanitarium.

Treatment of older patients suffering from tuberculosis is one of our major problems in the eradication of the disease. A third of the patients in sanatoria are over forty years of age. Temporary forms of collapse treatment in older patients are less apt to be successful than the permanent form provided by thoracoplasty. One hundred sixty-two patients between the ages of forty and sixty-five treated by thoracoplasty showed improvement of 84 per cent, with 35 per cent returning to work.—Richard H. Overhold, M. D., *Amer. Rev. of Tuberc.*, February, 1940.

¹ Kerlan, Milton: A Report of Two Cases of Streptothrix of the Lungs, *Med. Jour. & Record*, vol. 135 (Feb. 17), 1932.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

HARRY H. WILSON.....President
HENRY S. ROGERS.....President-Elect
LOWELL S. GOIN.....Speaker
PHILIP K. GILMAN.....Council Chairman
GEORGE H. KRESS.....Secretary and Editor

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1. *Executive Committee Minutes.*
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5. *Committee on Postgraduate Activities.*
6. *C. M. A. Department of Public Relations.*
7. *California Physicians' Service.*
8. *County Societies.*
9. *In Memoriam.*
10. *Woman's Auxiliary to the California Medical Association.*
11. *Nevada State Medical Association.*

OFFICIAL BUSINESS

CALIFORNIA MEDICAL ASSOCIATION EXECUTIVE COMMITTEE

Digest of the Minutes of the One Hundred and Seventieth (170th) Meeting of the Executive Committee of the California Medical Association

Held in the offices of the Association, Room 2004, 450 Sutter, San Francisco, California, Sunday, September 15, 1940, at 10 a. m.

1. Call to Order.

The meeting was called to order by Chairman Charles A. Dukes. The following members were present: Henry S. Rogers, Lowell S. Goin, Philip K. Gilman, Donald Cass, Charles A. Dukes, and George H. Kress.

2. Financial.

(a) Council Chairman Gilman reported that he approved the suggestion of the Association Treasurer that two new savings accounts be authorized:

(1) "Herzstein Bequest Fund of California Medical Association" account in the Wells Fargo Bank and Union Trust Company: savings account No. 70290 (deposit, \$802.26); and

(2) "California Medical Association Permanent Endowment Fund"; savings account No. 11362 (deposit, \$242).

Doctor Gilman stated that these accounts had been opened in order to maintain the integrity of the respective funds, since the monies accruing to each had been given to carry out specific purposes. The action authorized by Council Chairman Gilman was approved by the Executive Committee.

(b) Report was made that the United States Treasury Department, through the local Commissioner of Internal

† For complete roster of officers, see advertising pages 2, 4, and 6.

Revenue, in a letter dated August 31, 1940, had denied the claims of the California Medical Association for refunds on moneys paid for excise taxes and penalties. The Legal Counsel was instructed to make a report thereon at the October 6 meeting of the Council.

(c) Resignation of Miss Lucile Bradford as bookkeeper was received and, on motion duly made and seconded, was accepted, with appreciation for her long period of past service.

3. Medical Preparedness.

Dr. Philip K. Gilman, Chairman of the California Committee on Medical Preparedness, and Dr. Charles A. Dukes, a member of the California State Council of Defense, outlined plans thus far made concerning this important work.

4. Survey of Association Offices.

Dr. Philip K. Gilman, Chairman of the Special Subcommittee, authorized by the Council at its meeting on June 29, reported that this subcommittee had unanimously agreed to recommend that Mr. John Hunton, a resident of San Francisco, whose qualifications had been noted in a letter sent out to members of the Council, be employed as **business manager of the Association**. Doctor Gilman stated that Mr. Hunton would be able to take up his work on October 1, 1940.

5. Annual Session.

(a) A report was made by Doctor Kress, Chairman of the Committee on Scientific Work concerning the plans for more extensive scientific exhibits to be displayed at the next annual session in Del Monte.

Upon motion duly made and seconded, it was voted that the Committee on Scientific Work be authorized to offer prizes and certificates of award; the grand total of prize moneys not to exceed \$200.

(b) Upon motion duly made and seconded, Dr. Mast Wolfson of Monterey was elected chairman of the Local Committee on Arrangements.

6. Letter from the Los Angeles County Medical Association.

A letter from the Los Angeles County Medical Association, dated August 12, 1940, calling attention to a recent announcement by the Associated Hospital Service of Southern California in regard to indemnification for x-ray and laboratory services, was considered.

On motion by Lowell S. Goin, duly seconded, it was voted to recommend to the California Medical Association Council that the Council withdraw approval of the Associated Hospital Service of Southern California if steps are not taken by that organization to comply with the conditions laid down at the time original approval was given by the California Medical Association.

7. Woman's Auxiliary: Use of Ball Room at Del Monte.

Request of representatives of the Woman's Auxiliary to the California Medical Association to use the Ball Room of the Hotel Del Monte on Monday evening, May 5, 1941, in order to provide ample facilities for certain entertainment features was considered. Because the House of Delegates of the California Medical Association consists of 167 members, with many alternates and members of the Association

(Continued on Page 182)

(COPY)

Rocky Mountain

OCTOBER
1940Colorado
Utah
Wyoming

Medical Journal*

Editorial

(COPY)

Mr. Roosevelt Replies

IF you read this page of our September issue, you remember that it reproduced, photographically, a letter from the Republican Presidential candidate and explained the circumstances leading up to preparation of that letter. The letter, dated August 7, 1940, at Colorado Springs, contained only three short sentences in addition to address, salutation, and signature, as follows:

"My Dear Doctor—You have asked my views on socialized medicine. I am against it. You can quote me any place on this. Cordially yours, (Signed) Wendell L. Willkie."

You will also remember this *Journal's* offer of identical space in this, our October issue, to President Roosevelt, should he care to reply as the Democratic candidate. This offer was carried also in a letter to Mr. Roosevelt, dated August 22, 1940, enclosing a proof of the editorial page then on our presses for the September issue.

We have received the following letter from the White House, with which was enclosed a mimeographed copy of an address delivered by Mr. Roosevelt on the occasion of the dedication of the Jersey City Medical Center. Both are reproduced in full:

THE WHITE HOUSE
Washington

September 6, 1940.

Dear Mr. Sethman:

This acknowledges your letter of August twenty-second with enclosure. The President's views on the subject about which you inquire were expressed in a speech delivered at the Jersey City Medical Center, Jersey City, New Jersey, on October 2, 1936, and, for your information, I have much pleasure in enclosing a copy of that speech. The views expressed by the President on that occasion have in no wise been changed or modified since the delivery of the speech in question and still constitute a complete statement of his principles.

(Signed) STEPHEN EARLY,
Secretary to the President.

Enclosure.

"It is a privilege to take part in the dedication of this Medical Center—the third largest medical institutional group in the United States.

"I am happy, too, that the Federal Government, through its Public Works expenditures, has been able to be of assistance to the municipal government of Jersey City and to

Hudson County in making this Center possible. As a matter of fact, the expenditures through the Public Works Administration are increasing the capacity of American Hospitals by nearly 50,000 beds. During the depression the difficulty of obtaining funds through municipal or private sources would have meant a serious shortage in caring for patients and in giving them adequate facilities had it not been for Federal assistance through loans and grants.

"But there is another reason for increasing the bed capacity of the hospitals of the country. The medical and nursing professions are right in telling us that we must do more to help the small-income families in times of sickness.

"Let me, with great sincerity, give the praise which is due to the doctors of the Nation for all that they have done during the depression, often at great sacrifice, in maintaining the standards of care for the sick and in devoting themselves without reservation to the high ideals of their profession.

"The medical profession can rest assured that the Federal Administration contemplates no action detrimental to their interests. The action taken in the field of health as shown by the provisions of the splendid Social Security Act recently enacted is clear.

"There are four provisions in the Social Security Act which deal with health; and these provisions received the support of outstanding doctors during the hearings before Congress. The American Medical Association, the American Public Health Association, and the State and Territorial Health Officers' Conference came out in full support of the public health provisions. The American Child Health Association and the Child Welfare League endorsed the maternal and child health provisions.

"This in itself assures that the health plans will be carried out in a manner compatible with our traditional social and political institutions. Let me make that point very clear. All states and territories are now cooperating with the Public Health Service. All states except one are cooperating in maternal and child health service; all states but ten in service to crippled children, and all states but nine in child welfare.

"Public support is behind this program. But let me stress, in addition, that the Act contains every precaution for insuring the continued support and cooperation of the medical profession.

"In the actual administration of the Social Security Act we count on the cooperation in the future, as hitherto, of the whole of the medical profession throughout the country. The overwhelming majority of the doctors of the nation want medicine kept out of politics. On occasions in the past attempts have been made to put medicine into politics. Such attempts have always failed and always will fail.

"Government, state and national, will call upon the doctors of the nation for their advice in the days to come.

"It is many long years ago that Mayor Hague and I discovered a common interest in the cause of the crippled child. This great Medical Center is, I know, close to his heart. I congratulate him on the fulfillment of a splendid dream. I congratulate Jersey City and Hudson County on modern facilities surpassed by no other community in America."

* CALIFORNIA AND WESTERN MEDICINE, in its September issue, on page 133, reproduced a page from the August issue of the *Rocky Mountain Medical Journal*, giving candidate Willkie's views on "Socialized Medicine." This present page reflects the opinions of President Roosevelt. See also additional statements which follow.

**Letter from Stephen T. Early, Secretary to
President Franklin D. Roosevelt**

In addition to the information contained in the reproduction of an editorial page from the *Rocky Mountain Medical Journal*, given on the preceding page, the following communications have been received:

(COPY*)

September 24, 1940.

Dr. George H. Kress, Secretary and Editor,
California Medical Association,
450 Sutter Street,
San Francisco, California.

My Dear Dr. Kress:

I am directed to offer you the following statement for publication in *CALIFORNIA AND WESTERN MEDICINE*, as quoted from President Franklin D. Roosevelt:

"There is nothing more important to a nation than the health of its people."

"Let me, with great sincerity, give the praise which is due to the doctors and nurses of the nation for all that they have done during those difficult years that lie behind us, often at great sacrifice, in maintaining the standards of care of the sick and in devoting themselves without reservation to the high ideals of their profession."

"These professions can rest assured that the Federal Administration contemplates no action detrimental to their interests."—Franklin D. Roosevelt.

Yours very sincerely,

STEPHEN T. EARLY,
Secretary to the President.

✓ ✓ ✓

Dr. Elmer Belt of Los Angeles has requested the insertion of the following statement:

September 24, 1940.

To the Editor:—Dr. Elmer Belt, President of the California State Board of Health, presents the following facts from the thirty-fifth biennial report of the Department of Public Health of California, regarding cooperation of the Federal Administration with the Health Department of the State of California:

Through the provision of Social Security funds, services covering industrial hygiene, public health nursing, county health work, maternal and child welfare and services to physically handicapped children were undertaken by the California State Department of Health. Funds provided by the Federal Government for carrying on these undertakings totaled \$732,501.98 during the biennial period that ended June 30, 1938. All of these services maintained through the provision of federal funds under the Social Security Act were conducted the same as the routine activities of the State Department of Health. All personnel employed under Social Security come under the provisions of the State Civil Service Law. No positions under any of these public health services, financed through Social Security funds, were outside of the state civil service.

Maternal and child welfare activities were conducted within the Bureau of Child Hygiene under the general supervision of the chief of that bureau, while other activities, such as industrial hygiene, crippled children services, public health nursing, and county health work were conducted by newly organized independent services. The organization and direction of these services and the disbursement of Social Security funds was under the direction of Howard Morrow, M.D., Edward M. Pallette, M.D., William R. P. Clark, M.D., George H. Kress, M.D., Gustave Wilson, M.D., Roy A. Terry, M.D., V. A. Rossiter, D.D.S., and Walter M. Dickie, M.D.

The administration of such funds and of these services was and will continue to be under the direction of the doctors of the California State Board of Health.

These are deeds, not platform promises.

* The letter which follows was received from Dr. Elmer Belt and Associates, with the statement that it had been approved by Secretary Stephen T. Early.

EXECUTIVE COMMITTEE MINUTES

(Continued from Page 180)

Medical Association also present, and because the Bali Room is the only available meeting space for a meeting of the House of Delegates on Monday evening, it was voted that it would not be possible to grant the request of the Auxiliary for release of the Bali Room for entertainment features.

8. Los Angeles County General Hospital.

Dr. Lowell S. Goin called attention to certain problems which had arisen at the Los Angeles County General Hospital. It was agreed that it would seem to be in order for the Los Angeles County Medical Association to prepare a memorial or letter to be presented to the California Medical Association Council on October 6, in which would be outlined the principles at issue. The Council could then take up consideration of the principles involved.

9. Indemnity Defense Fund.

The Association Secretary reported on the steps that had been taken to compile an accurate listing of past and present members of the Fund; stating that up to the present time a total of 117 members had not assigned their interests (their proportion of \$10 to \$40 each) to the "Trustees of the California Medical Association." Doctor Kress read a letter which had been sent to each of these members. (The approximate amount of moneys to the credit of the savings accounts of the Indemnity Defense Fund is \$46,840. The total number of physicians who were members of the Fund is 1,433, and all but 117 of these have assigned or lapsed their interests therein to the "Trustees of the California Medical Association.")

10. Medical Exhibits at Golden Gate International Exposition.

The desirability of salving some of the medical exhibits at the Golden Gate International Exposition, which would close on September 29, for possible future use at state and county fairs, was discussed. A special committee was authorized to investigate this matter with authority to make arrangements for proper storage.

11. Adjournment.

GEORGE H. KRESS, Secretary.

Attest:

CHARLES A. DUKES, Chairman.

**CALIFORNIA COMMITTEE ON
MEDICAL PREPAREDNESS**

Dr. Philip K. Gilman, Chairman of the California Medical Association Committee on Medical Preparedness, recently sent to County Society Committees on Medical Preparedness the following letter:

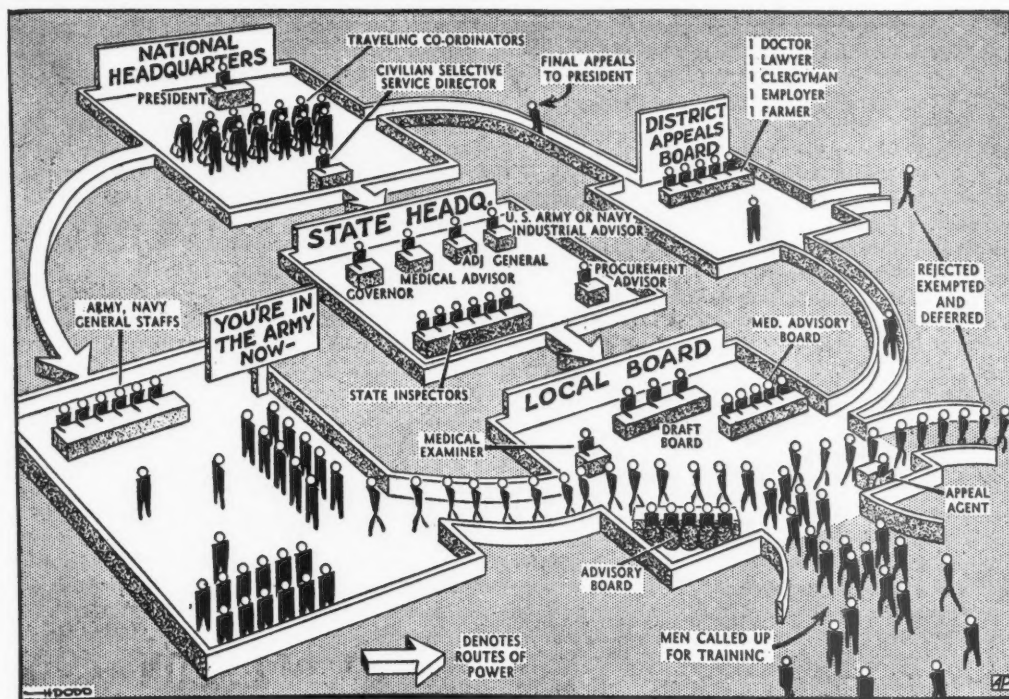
Dear Doctors:

The "Military Preparedness" sections of *The Journal of the American Medical Association* and *CALIFORNIA AND WESTERN MEDICINE*, in recent issues, have explained the progress that has been made, in securing for the Military Departments of the Government, that adequate information concerning the members of the medical profession of the United States, which is vitally necessary if the best service is to be rendered to the Army, Navy and Public Health divisions, and to the civil population as well. None of us can say when the great emergency will arise.

✓ ✓ ✓

The American Medical Association questionnaire sent from Chicago to every physician is the means through which needed information will be obtained for the military arms of our country.

It is most important that every physician should mail his reply to the American Medical Association at 535 North Dearborn Street, Chicago, as promptly as possible.



A diagram of the conscription measure gives a picture like this. Men flow from the local draft boards to the Army and to the Navy when they are needed. Appeals flow to Appeal Boards.—San Francisco *Call-Bulletin*, September 25, 1940.

If this has not been done, or if a new questionnaire is needed, a request to the California Medical Association, 450 Sutter Street, San Francisco, will bring the proper blanks.

As chairman of the California Committee on Medical Preparedness, I am writing to you, since you are one of the county chairmen, to request you to check on the physicians in your county, and to urge all who have not done so, to send in their questionnaires. (You are at liberty to appoint as many colleagues to assist you in this work, as you may deem proper.)

With a set-up of yourself as chairman or captain, you contacting a certain number of aides or lieutenants, and they in turn each responsible for contacting, by telephone, say, ten physicians, it should be possible for you to get a fairly good estimate of the extent to which the physicians in your county have cooperated.

Dr. Charles A. Dukes of Oakland, who is one of the ten members of the American Medical Association committee, and the undersigned, go to Chicago for a meeting on September 20, at which time every state medical association will make its report.

I am hoping to make a good report for California, and with your help it will be possible. Without your prompt cooperation, I shall be in an embarrassing position. I am counting on your aid.

For your convenience, I am enclosing a blank on which you can make at least a tentative report. Reply envelope is also enclosed.

Your report should be in my hands in San Francisco not later than Saturday, September 14, because Doctor Dukes and I leave for the East on Tuesday, September 17.

May I not hope to hear from you as promptly as possible? With thanks for your cooperation in this important work, I am

Cordially yours,

(Signed): PHILIP K. GILMAN, M. D.,
Chairman, California Committee on
Medical Preparedness.

It is hoped that the members of the California Medical Association who have not sent their questionnaire replies to the American Medical Association Committee on Medical Preparedness, 535 North Dearborn Street, Chicago, Illinois, will do so. If the reply blank has been misplaced, a request for a duplicate set should be sent to the California Medical Association Committee on Medical Preparedness, 450 Sutter Street, San Francisco.

* * *

(COPY)

CALIFORNIA MEDICAL ASSOCIATION

San Francisco, September 23, 1940.

To the Councilors, Presidents, and Secretaries of County Medical Societies:

Dear Doctors:

At the recent joint meeting of the Trustees of the American Medical Association, the Committee on Medical Preparedness of the American Medical Association and the Chairmen of the State Committees on Medical Preparedness held in Chicago, September 20, 1940, at which meeting also representatives of the Medical Corps of the Army, Navy, and Public Health Service were in attendance, many important subjects relative to medical preparedness were discussed. A synopsis of this meeting will appear in an early issue of *The Journal of the American Medical Association*.

Matters considered in order of their importance were as follows:

1. *Completion of the questionnaires.* This is particularly important in relation to physicians in the draft age. We advise and urge early completion of these questionnaires and believe that doctors who are in the draft age should volunteer, so that their classification as to qualifications would place them in a preferable position in the preparedness program. Should such an emergency arise, the above

procedure would certainly lessen confusion in the placement of medical officers.

2. *All physicians, whether in the draft age or not, should complete their questionnaires at once*, so that those in special groups may be properly placed when and if the Government requires their services.

Physicians neglecting to send in their questionnaires will necessarily be classified according to the information carried in the American Medical Association Directory. This information being less complete than that contained in the questionnaire may lead to confusion, faulty classification, and undesirable placement.

* * *

Methods to secure the return of the questionnaires were discussed at this meeting and the following are suggested to county medical societies:

- (a) By return postal card;
- (b) By local committee;
- (c) By telephone requests.

Owing to the urgency of the situation, immediate personal visits or telephone requests are recommended.

It is suggested that use be made of the Woman's Auxiliary to aid you. The Auxiliary has offered to cooperate in any manner requested.

We, therefore, cannot urge you too strongly to see that each member, who has not already done so, immediately complete and forward his questionnaire.

An immediate reply to this letter is requested. Address: California Medical Association Committee on Medical Preparedness, 450 Sutter, San Francisco.

Sincerely yours,

C. A. DUKES,

*Member, Committee Medical Preparedness
American Medical Association.*

P. K. GILMAN,

*State Chairman, California Committee on
Medical Preparedness.*

* * *

Medical Participation in Selective Service*

By CHARLES B. SPRUIT

Lieutenant Colonel (M.C.), General Staff Corps, United States Army; Medical Adviser to the Joint Army and Navy Selective Service Committee Washington, D. C.

THE RÔLE OF THE PHYSICIAN

... Inauguration of selective service brings a new responsibility to the medical profession and another opportunity of service to the nation. The rôle of the physician in the Selective Service mechanism will be to examine, to find, to evaluate and to recommend. The local board and the appeal board will determine the final classification of all registrants. It is believed that the participation of the physician of the community in determining the physical qualifications of registrants will promote confidence in the fairness of the system and permit of a more accurate determination of the ability of a man to perform military service. The intimate knowledge that the local physician has of the members of his community should be of marked assistance not only in the determination of physical fitness, but also in the detection of malingering on the part of men seeking to evade service. . . .

THE LOCAL EXAMINING PHYSICIAN

The physical examinations of Selective Service will be made by local examining physicians, who act as agents of the local boards for this purpose. When necessary, additional examining physicians may be appointed by the

local board. The local examining physician will examine all registrants sent to him by the local board according to the standards of physical examination which will be furnished him. He will note all deviations from the normal on physical examination forms and then interpret them in the light of the physical standards and in terms of the ability of the registrant to perform full military service. Thereafter he will record his recommendations to the local board as to the physical qualifications of the man to do full or limited military service. If the registrant possesses defects that disqualify him for any military service, that fact, likewise, will be entered. In those cases in which the local board has appointed additional examining physicians, it may be feasible in certain communities to form an examining group to facilitate and expedite the examinations.

MEDICAL ADVISORY BOARDS

Medical advisory boards will be appointed by the President, on the recommendation of the state, to provide an agency of advice and assistance to examining physicians and to assist appeal boards in determining matters of physical fitness which have been appealed from the decision of the local board by the registrant or by the Government agent. The medical advisory boards will as far as practicable comprise internists, ophthalmologists, otolaryngologists, orthopedists, surgeons, psychiatrists, clinical pathologists, radiographers, and dentists.

MALINGERING

The experience of Selective Service during the last war showed the necessity of constant vigilance to detect malingering. Many men descended to self-mutilation and numerous other more ingenious but less harmful subterfuges to escape military service. Malingerers will doubtless be encountered in the coming operation of Selective Service. Regulations on physical standards mention many of the more common practices used by malingerers to feign disability and describe methods by which these may be detected.

THE MEDICAL TASK

The fall increment of some 400,000 men will be distributed according to quotas to the several states and by each state headquarters to the local boards in that state. On the assumption that these 400,000 men will be equally divided among the 6,500-odd local examining boards, and utilizing the World War percentage of rejections by examining physicians of Selective Service and of the Army, there will be about ninety men per local board for physical examination. As these men will not all be inducted immediately but will be called up during the following three or four months, the average examination load on each board will probably be between twenty and thirty men per month. These calculations are not applicable to each local board because the quota assigned to a local board takes into consideration certain credits to that community accruing from men presently in the regular services or active National Guard. The total appeals on physical grounds during the World War indicate a lesser load on medical advisory boards. The additional number of cases sent up for advice by local examining physicians is not known.

STATE HEADQUARTERS

The state headquarters operating under the governors of the several states are charged with the organization and operation of the Selective Service system within the respective states under the policies and procedures authorized by the President. For each state the President will designate one or more officers of the Medical Reserve Corps of the Army and Navy as medical assistants on the staffs of the several governors. They will assist the state authorities in the supervision and coordination of medical examinations throughout the state. They will establish

*The following are excerpts from an article in *The Journal of The American Medical Association*.

and maintain liaison with all examining physicians and members of medical advisory boards, hold regional meetings for them to promote critical discussion and analysis of the medical problems of selective service, and visit medical advisory boards, local boards, and examining physicians to advise and assist all concerned with physical examinations. They will keep the necessary records and statistical analyses of the operation of the medical function of Selective Service within the state.

NATIONAL HEADQUARTERS

The National Selective Service Headquarters in Washington will contain a compact medical division, which will assist the director of Selective Service in the determination of policy on medical matters and have general direction and coordination of the medical functions through the state headquarters and the medical assistants in each state. . . .

* * *

Nominations for Registration Board Members Sent to Washington by Officials

Los Angeles County moved swiftly yesterday in its efforts to aid the Government in conscripting America's first peace-time Army.

Superior Judge Peirson M. Hall, representing Governor Olson, announced that all registration boundaries have been officially fixed, added that he and his associates have been accorded "gratifying coöperation on all sides" and congratulated county officials for prompt measures in setting up preliminary draft machinery.

"This," said Judge Hall, "will aid us quite materially when we come to draft day on October 16. All this preparatory work, performed ungrudgingly and in a fine spirit of patriotism, has been of inestimable value to those in charge of the initial steps."

SERVE CHEERFULLY

Judge Hall, checking off various points in his daily agenda, said:

"Nominations of those who may serve on the draft and appeal boards have not only been completed, but the various nominees have been contacted and, in every case, have cheerfully agreed to serve.

"Although we are not positive whether three or five members will be expected to serve on the draft boards, we have, in every instance, certified six names to Washington. Thus they may choose at their own discretion.

"In the case of the appeal boards, we sent in lists of five, for the same reason.

AHEAD OF SCHEDULE

"Each draft board will have its own medical adviser and alternates. Medical advisers for the appeal boards will be nominated by the State Medical Association.

"There also will be advisory boards of thirty, with chairmen designated by Governor Olson, to assist draftees in filling out their questionnaires.

"All these, of course, will serve without pay, and all those contacted thus far have readily agreed to do so. On the whole, the draft machinery, as far as this country is concerned, is not only moving on time, but is ahead of schedule. There should be little friction when the actual registration starts."

Judge Hall, working with Adjutant-General R. E. Mittelstaedt and other California representatives, pointed out that the "utmost publicity will prevail throughout the draft, as well as during its preliminary steps," and predicted that the ensuing training will be conducted on a basis satisfactory to all.

"One point in particular should be stressed," Judge Hall continued, "and this is the fact that the success of this great defense program depends upon the men themselves.

"By this, I mean that the men selected for service must have a healthy reaction to camp life or the whole structure is endangered."

He explained that, with this in mind, the Federal Government will see to it that few, if any, men will be called into service until adequate preparations have been made by the Army to care for them properly. This, he indicated, takes into consideration ample camp facilities, clothing, food, and all necessary items in camp routine. . . .—Los Angeles Times, September 20.

* * *

Health Board Appointed—Group to Coöperate in Defense Program Headed by Kentuckian

Washington, September 19 (AP).—President Roosevelt named today a committee to coöperate with the Defense Commission on all phases of public health as an additional means of strengthening the nation for any emergency.

Under the authority of an act of 1916, he named five men "to advise the Council of National Defense regarding the health and medical aspects of national defense and to coordinate health and medical activities affecting national defense."

Named as chairman was Dr. Irvin Abell of Louisville, Kentucky, chairman of the Board of Regents of the American College of Surgeons.

OTHER MEMBERS

The other members of the Medical Advisory Committee are Dr. Lewis H. Weed, Chairman of the Division of Medical Sciences of the National Research Council; Rear Admiral Ross T. McIntire, Navy Surgeon-General and White House physician; Major General James C. Magee, Army Surgeon-General; and Dr. Thomas Parran, Surgeon-General of the United States Public Health Service.

McIntire, explaining the President's action to reporters, said probably 16,000 additional physicians will be needed to handle 900,000 prospective conscripts. There are about 180,000 members of the medical profession in the country, he continued.

PROPER SPREAD

Every effort will be made, he said, to see that there is a "proper spread" of surgeons and nurses, and the question of correlating health and defense problems will be handled in a "careful way" so as "not to upset the civilian side" of medical care.

In the World War, he said, the country mobilized primarily to send an army overseas.

"Today," McIntire asserted, "we are thinking of getting the whole country ready to take care of itself. So, the medical profession has been looking ahead to the proper distribution of hospital beds, nurses, doctors, and medical facilities."

For two months, he said, the American Medical Association has been making a survey of its members to get an idea what they could do and would like to do to coöperate with the preparedness program. About 100,000 answers to questionnaires have been received, he added.—Los Angeles Times, September 20.

* * *

University of California Naval Medical Unit Prepared to Battle Plagues

In the midst of eleventh-hour national defense preparations, with many people wondering whether America can get ready for a total war impact within the next year or so, the University of California and the Navy Department announce that they are ready immediately to put a

fully trained, fully equipped medical laboratory unit in the field for the purpose of studying and controlling epidemics in mobilization camps and elsewhere. The unit has been in training for seven years under the direction of Dr. A. P. Krueger, professor of bacteriology and commanding officer of the unit, who was recently selected for promotion to the rank of commander in the navy. Second in command is Dr. Robert Alan Hicks of Tucson, Arizona. Each member of the unit enters the organization as a chief naval petty officer.

Foresight in providing for this vital unit seven years ago is credited to Admiral Rossiter, surgeon-general of the navy in 1934, and to Doctor Krueger, who suggested the unit to Admiral Rossiter. One of its principal advocates at the present time is Dr. Ross McIntire, personal physician to President Roosevelt and present surgeon-general of the navy.

The unit is the first of its kind in the United States and is known as Naval Laboratory Research Unit No. 1. Some time ago a second unit was formed in the East. The fact that the navy now has this group of specially trained medical men means that in any possible concentration of navy men under the conscription bill or otherwise, the development of epidemics and other rampant infections will be investigated at the start, thus insuring that a maximum number of effectives will be kept available for actual naval service.

COMMITTEE ON PUBLIC HEALTH EDUCATION†

Under the auspices of the Committee on Public Health Education, notices to renew interest in the essay contest on "The Role of the Doctor of Medicine in the Life and Health of the American Citizen," have been sent during the past month to 575 high schools, junior colleges, parochial schools, and private schools. This contest closes in November and efforts are being made to get all replies possible in on time.

Inquiries from contestants in the scenario contest, which is preliminary to the motion picture to depict the scientific advancement and achievements of doctors, have been answered and the proper entry blanks forwarded to those seeking to enter the contest.

Ninety-one chairmen of Adult Education Forum discussion groups in California evening high schools have been notified that doctor-speakers are available to appear before their groups and they have been given a list of the forty California Medical Association Speakers' Bureaus secretaries so they will know where to request speakers.

Lists of the adult forum discussion groups with their addresses have been sent to the forty secretaries of the Speakers' Bureaus to enable them, if they can do so, to arrange to place their speakers before the discussion forums in their vicinities.

Requests for speakers have been received from various parts of the state for dates as far ahead as next May and the Committee on Public Health Education, through its public relations counsel, will arrange at the proper times with speakers' bureaus to provide speakers for these dates.

† The Committee on Public Health Education was established through Substitute Resolution No. 6 at the Del Monte annual session, May 3, 1933.

The Committee on Public Health Education consists of Frank E. Makinson, chairman, Oakland; Philip K. Gilman, secretary, San Francisco; Samuel Ayres, Jr., Los Angeles; Thomas A. Card, Riverside; Lowell S. Goin, Los Angeles; Junius B. Harris, Sacramento; Harry H. Wilson (ex officio), Los Angeles. Mr. Ross Marshall is the Public Relations Counsel of the Committee, and may be addressed at 408 South Spring Street, Los Angeles (telephone TUCKER 2312), or 244 Kearny Street, San Francisco (telephone YUKON 2212).

One state-wide publicity story has been issued during the past month regarding the essay and the scenario contests and, now that the summer season is over, more stories will follow when actual news value warrants. It may be pointed out that publicity at this time is a difficult problem, owing to the great demand for space for war news and the political campaign.

Your Public Relations Counsel spoke at the postgraduate meeting of the Eighth District at Lake Tahoe on August 25, explaining the work of the Committee.

During the month your Public Relations Counsel has conferred with the legal department and representatives of the Public Health League concerning the Basic Science Initiative and is giving full assistance in the plans for this important activity. R. M.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Third Councilor District (Kern, San Luis Obispo, Santa Barbara, and Ventura Counties) the First Councilor District to Inaugurate Councilor Postgraduate Conferences

In the September issue (page 106) the Eighth Councilor District was referred to as having been the first councilor district to inaugurate a postgraduate conference. That statement was in error because the honor belongs to the Third Councilor District, as may be noted by perusal of the letter which follows, received from Dr. Louis A. Packard, Councilor of the Third District, who gave much effort in promoting the successful conferences held at Bakersfield and Santa Barbara.

Doctor Packard's letter follows:

Bakersfield, California,
September 12, 1940.

Dear Doctor Kress:

I noted with interest your comment in *CALIFORNIA AND WESTERN MEDICINE*, in the September issue, on Councilor District Postgraduate Conferences; and note particularly that you say: "To the Mother Lode Councilor District . . . will belong the honor of having been the first of the nine Councilor Districts of the California Medical Association to have proposed and carried through to a successful conclusion a postgraduate conference for the members of the component county societies included in its councilor territory."

In the article following, still devoted to the subject you state: "Query: Which of the other eight councilor areas will be the first to follow the example set by the Mother Lode Eighth Councilor District?"

Please recall that in 1938, 1939, and 1940 the Third Councilor District has held a Third District Conference; in 1938 and 1939 in Santa Barbara, and in 1940 in Bakersfield; that all of these have been for and by the constituent counties of the Third District and that the average attendance for the two days has been in excess of one hundred. While it is too early to give any definite information, I feel quite certain that the fourth annual conference of the Third District will be held in 1941. I am sure you will recall at least the 1940 meeting since you were present at that time.

The session held at Tahoe appeared to be a very well prepared one and only the fact that I was out of the State at the time prevented me from attending. I suggested this type of a conference to the Postgraduate Committee at Coronado and described to them the district conference we had held. This conference at Tahoe, I think, was the first to be held in the State along the lines of our Third District meetings.

With kindest regards, I am

Sincerely yours,

LOUIS A. PACKARD, M. D.,
Councilor, Third District.

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

The much discussed basic science law for California is on the road to completion. In 1939 the Committee on Public Relations gave much thought to the proposed initiative law, making three revisions thereof. Much aid was received from W. C. Woodward and J. W. Holloway, Jr., of the American Medical Association Bureau of Legal Medicine, that Bureau having had considerable experience in the drafting of most of the basic science laws that are now in operation. The decisions reached by the Committee on Public Relations in 1939 and 1940 were incorporated into the proposed law by the legal department of the California Medical Association, through Legal Counsel Peart and his associate, Mr. Hassard.

The fourth draft, which may be said to be almost the final draft of the proposed law, is now under consideration by professional groups affiliated with medicine. It is hoped that, on or before November 1, 1940, it will be possible to submit the final draft to the Attorney-General of California for title. Once the title is received, it will be in order to print the petitions for signatures of voters. At the present time, a total of 212,000 valid signatures are necessary to qualify a proposed initiative for place on a state ballot. Because a large number of signatures are found to be invalid (see CALIFORNIA AND WESTERN MEDICINE, August 1940, on page 56, for comments concerning signatures), it has been found necessary to have at least 100,000 additional signatures over and above the stipulated number. It is possible that the basic number of 212,000 may be increased, depending upon the number of voters who go to the polls in the presidential election in November, 1940.

Once the procedures noted above are completed, component county medical societies and members of the Association will receive additional information concerning the work ahead.

CALIFORNIA PHYSICIANS' SERVICE*

California Physicians' Service beneficiary memberships have reached a total of 17,400 dues-paying members during the month of September, in approximately 625 groups.

A program of expansion in the San Joaquin Valley was inaugurated on September 24 with a dinner meeting, at which the Fresno County Medical Society acted as host to 160 business men, civic leaders, physicians, and others. The dinner was planned by the County Medical Society as a means of introducing the idea of California Physicians' Service to business men and community leaders. Dr. Dewey R. Powell of Stockton, a member of the Board of Trustees

of California Physicians' Service, described to the group the intent behind the movement on the part of the medical profession and warned against "regimentation of compulsory medical service," pointing out that physicians themselves are the ones best fitted to meet the medical needs of the community. Mr. J. Philo Nelson, general manager of the service, from San Francisco, described the progress of nonprofit hospital plans throughout the country, and described in considerable detail the protection offered through California Physicians' Service and the nonprofit hospital associations.

As previously announced, Mr. H. B. Rector is now located in Fresno as Field Representative for the entire San Joaquin Valley area, with headquarters in the T. W. Patterson Building.

The study of statistics referred to in previous issues continues, and will be reported upon in considerable detail in the near future. We find that during the month of May, when there were 5,112 professional members in the state, that 1,057 doctors, or 20.6 per cent of the professional members, participated. There were 10,514 units of service rendered, for which \$13,142.50 was disbursed to physicians, at a unit value of \$1.25, which represents an average of \$12.43 per professional member.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (44)

Alameda County (1)

Kenelm Winslow Benson, Berkeley

Lassen-Plumas-Modoc County (1)

Herman Swartzman, Belden

Los Angeles County (27)

Frank Manter Anderson, Los Angeles
Maynard S. Bourdeau, Glendale
Ernest George Burrows, Inglewood
Edwin S. Chapmann, San Fernando
Harold Arnold Cohn, Los Angeles
Hyman Engelberg, Los Angeles
Rygel E. Farrand, Pasadena
W. Arden Fate, Los Angeles
Paul Hanson, San Marino
Horace W. Jamison, Los Angeles
Harry E. Kerber, Glendale
Monroe Franklin Loy, Los Angeles
Harold J. Magnuson, Los Angeles
Harold R. Ostrander, Los Angeles
Max Edward Pohlman, Los Angeles
Henry Salvatore Portogallo, Los Angeles
Charles Edward Romaly, Los Angeles
Norman Reider, Los Angeles
Maurice B. Rogers, Los Angeles
Eugene Rosenman, Los Angeles
Lewis F. Seapy, Long Beach
Edward Shapiro, Los Angeles
Ludwig Strauss, Los Angeles
Wendell W. White, Los Angeles
John C. Wilcox, Pomona
Geoffrey Williams, West Los Angeles
N. John Zahry, Los Angeles

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. Donald Cass of Los Angeles is the chairman, and Dr. George H. Kress is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. George H. Kress, Room 2004, Four Fifty Sutter Street, San Francisco.

* Address: California Physicians' Service, 333 Pine Street, San Francisco. Telephone: EXbrook 3211. Alson Kilgore, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

† For roster of officers of component county medical societies, see page 4 in front advertising section.

Concerning absence in this issue of letters from county societies, see comment on page 154.

San Diego County (4)

James D. Edgar, *San Diego*
 Morris John Kotler, *San Diego*
 John A. Norton, *Oceanside*
 Lawton E. Shank, *San Diego*

San Francisco County (6)

Robert B. Alexander, *San Francisco*
 Charles C. Impey, *San Francisco*
 Jesse J. Iverson, *San Francisco*
 Malcolm C. Johnson, *San Francisco*
 Karl A. Reed, *San Francisco*
 Maurice Sokolow, *San Francisco*

Shasta County (3)

John D. Briggs, *Weaverville*
 Roland R. Jantzen, *Redding*
 Harold R. Whiteside, *Redding*

Solano County (1)

Arnold Houser, *Vallejo*

Yuba-Sutter-Colusa County (1)

David Frost, *Williams*

Resigned (1)

Harvey M. Slater, from Santa Clara County.

Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✦

Schwuchow, Walter Bernard. Died at Los Angeles, September 3, 1940, age 62. Graduate of Rush Medical School, University of Chicago, 1903. Licensed in California in 1911. Doctor Schwuchow was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✦

Sullivan, William Reginald. Died at Merced, September 3, 1940, age 30. Graduate of the University of Kansas School of Medicine, Kansas City, 1935. Licensed in California in 1936. Doctor Sullivan was a member of the Merced County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✦

Whiteside, Harold Rowland. Died at Sacramento, September 8, 1940, age 36. Graduate of the University of Oregon Medical School, Portland, 1933. Licensed in California in 1934. Doctor Whiteside was a member of the Shasta County Medical Society, the California Medical Association, and the American Medical Association.

✦

In Memoriam

Burns, Ernest Madison. Died at Huntington Park, August 20, 1940, age 47. Graduate of the University of Nebraska College of Medicine, Omaha, 1921. Licensed in California in 1923. Doctor Burns was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✦

Clarke, Austin Fisher. Died at Oakland, August 18, 1940, age 68. Graduate of Kentucky School of Medicine, Louisville, 1892. Licensed in California in 1893. Doctor Clarke was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✦

Cowles, Danforth C. Died at Fullerton, August 28, 1940, age 64. Graduate of the University of Minnesota Medical School, Minneapolis, 1901. Licensed in California in 1916. Doctor Cowles was a member of the Orange County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✦

Jennison, John Egbert. Died at San Diego, August 19, 1940, age 72. Graduate of the University of Minnesota Medical School, Minneapolis, 1894. Licensed in California in 1909. Doctor Jennison was a member of the San Diego County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✦

Rosenberger, Homer G. Died at Los Angeles, August 13, 1940, age 60. Graduate of Rush Medical College, University of Chicago, 1907. Licensed in California in 1908. Doctor Rosenberger was a member of the Los

OBITUARIES

William Wesley Fitzgerald

1868-1940

William Wesley Fitzgerald, pioneer member of the San Joaquin County Medical Society, passed away at Stanford Hospital in San Francisco on July 7, 1940, of a pulmonary embolism after apparently convalescent from a laparotomy or intestinal complications due to amebic dysentery.

Doctor Fitzgerald was born about seven miles east of the city of Stockton on June 1, 1868, the son of a pioneer who had located in this section in 1851 and who planted the first vineyard and orchard in the Linden district.

Doctor Fitzgerald was graduated from the Jefferson Medical College in Philadelphia in 1895. In the same year he returned to Stockton and was licensed to practice.

Doctor Fitzgerald's wide acquaintance in his native city, his very unusual professional ability, and his charming personality won him a tremendous practice. His friends were fascinated by his recital of the problems of early-day practice in the pre-automobile era, when relays of horses were necessary to maintain the strenuous pace that the busy practitioner of that day had to keep up. The Doctor was always thoughtful and considerate of the younger men in practice.

Doctor Fitzgerald was surgeon for the Southern Pacific Railroad, and his many trips to Southern California made him interested in walnut culture. He believed that the climate and soil of San Joaquin County were adaptable to walnut growing and began a very intensive study of this problem. He crossed the English walnut onto the black walnut and established a commercial grove of sixty acres in 1909 and another grove of 100 acres in 1915. He was indeed a pioneer in the horticultural development which has meant much to this area in subsequent years.

When he retired from active professional work in 1918, his interest in walnut culture was indeed a life-saver for him. He maintained that interest continuously in the prob-

lem and was often sought out for advice, and lectured before many organizations on walnut-growing.

Down through the years Doctor Fitzgerald maintained a continuing interest in medical problems and in organized medicine even though he was no longer in practice. He manifested a keen interest in the California Physicians' Service and demonstrated that interest by sending in his \$5 membership fee as an expression of good will even though he knew he would never qualify as a professional member in active practice.

Those of us who knew and valued Doctor Fitzgerald through the years as a friend and a confrère will miss his genial smile and his gracious personality. The members of the San Joaquin County Medical Society extend to his surviving widow their sincere sympathy in her great loss.

D. R. P.

✦

Edmund Frost 1881-1940

The members of the San Joaquin County Medical Society were shocked and grieved to learn on the evening of June 26, 1940, of the sudden death of Dr. Edmund Frost.

Doctor Frost had been busily engaged in his usual professional activities at the hospital and office throughout the day and was stricken with a fatal heart attack at his home that evening.

Edmund Frost was born at Birkenhead, England, on November 10, 1881, and received his education in that country, where he received his degree in civil engineering from Yorkshire College at Leeds, England. He came to the United States in 1912 and received his medical training in the College of Physicians and Surgeons in San Francisco, graduating in 1917. He interned in the Stanford Service at the San Francisco County Hospital and spent two years as resident physician at the Santa Clara County Hospital.

During his nineteen years of residence in our city, Doctor Frost won many friends among the profession and the laity whom he served, by his quiet and gentlemanly demeanor and his conscientious attention to his professional responsibilities.

The members of this society extend to his widow and children their very sincere and heartfelt sympathy in their great loss.

D. R. P.

✦

Robert Beverly Taylor 1906-1940

On September 15 the friends and associates of Dr. Robert Taylor were shocked to learn of his tragic death after being thrown from his horse while riding in Golden Gate Park. Doctor Taylor was only thirty-three years of age, and for the past six years had been in general practice and assisting his father, Dr. Charles Taylor, at his offices at 450 Sutter Street.

Born in San Francisco and a graduate of Lowell High, Doctor Taylor attended Stanford and received his M. D. from Creighton Medical School in Omaha, Nebraska, in 1933. He then returned to San Francisco, where he remained from that time, with the exception of a postgraduate year in Vienna in 1937.

Although in general practice, Doctor Taylor had planned to become a surgeon like his father, with whom he worked as an assistant at Dante Hospital. His untimely death while pursuing his favorite sport has cut short prematurely a promising career, and the sincere sympathy of the Society has been extended to Dr. and Mrs. Charles Taylor, his parents, in their great loss.

H. M. F. B.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. A. E. ANDERSON.....President
MRS. WILLIAM C. BOECK.....Chairman on Publicity
MRS. KARL O. VON HAGEN.....Asst. Chairman on Publicity

Meeting of Board of Directors

A record attendance of thirty women greeted the new state president, Mrs. A. E. Anderson of Fresno, when she met with her Board of Directors in an all-day session at the Lake Merritt Hotel in Oakland on Friday, September 13. All the officers and councilors-at-large were present, as were six of the nine district councilors. In addition there were thirteen of the twenty-eight county presidents in attendance at the meeting.

Officers.—Mrs. A. E. Anderson of Fresno, president; Mrs. Harry O. Hund of San Rafael, president-elect and chairman of finance; Mrs. F. G. Lindemulder of San Diego, first vice-president and chairman of membership and organization; Mrs. Harry G. Huffman of Santa Ana, second vice-president and chairman of program and health education; Mrs. R. K. Cutter of Berkeley, recording secretary; Mrs. E. R. Scarboro of Fresno, corresponding secretary; and Mrs. C. G. Stadfield of Los Angeles, treasurer.

Councilors-at-Large.—Mrs. A. A. Alexander of Piedmont, chairman of public relations; Mrs. William C. Boeck of Beverly Hills, chairman of publicity; Mrs. Louis A. Packard of Bakersfield, chairman of *Hygeia*; and Mrs. John C. Sharp of Salinas, convention chairman.

District Councilors.—Mrs. G. W. Coon of Riverside, First District; Mrs. Franklin Farman of Los Angeles, Second District; Mrs. Richard McGovney of Santa Barbara (absent), Third District; Mrs. J. C. McClure of Lindsay (absent), Fourth District; Miss Julia Koencke of Salinas, Fifth District; Mrs. Eugene Kilgore of San Francisco, Sixth District (also chairman of public relations); Mrs. Charles C. Hall of Piedmont, Seventh District; Mrs. E. O. Brown of Sacramento (absent), Eighth District; and Mrs. Frank A. Lowe of San Francisco, Ninth District.

Mrs. Arthur Newcomb of Pasadena, historian, and Mrs. L. R. Willson of Fresno, parliamentarian, were absent.

The following presidents of county auxiliaries were present: Mrs. Ira Church of Alameda County, Mrs. Kaho Daily of Contra Costa County, Mrs. C. C. Landis of Butte County, Mrs. Ralph B. Eusden of Los Angeles County, Mrs. Lloyd G. Tyler of Marin County, Mrs. Ralph M. Smith of Riverside County, Mrs. George Briggs of Sacramento County, Mrs. G. H. Rohrbacher of San Joaquin County, Mrs. P. J. Hanzlik of San Mateo County, Mrs. Philip Haley of Santa Clara County, Mrs. A. J. Pederson of Santa Cruz County, Mrs. H. Randall Madeley of Solano County, and Mrs. A. E. Ghilotti of Stanislaus County.

Mrs. Anderson, President, presented her splendid program of aims, plans and projects for the year 1940-1941. This was received with enthusiasm and is printed herein. Committee chairmen all presented well-worked-out programs, and the alert spirit which prevailed throughout the meeting showed that the year is off to a flying start. Effort is to be directed toward increased membership and the organization of new county auxiliaries; toward increased circulation of *Hygeia*, the chief duty that the

†As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Karl O. Von Hagen, Assistant Chairman on Publicity, 2435 Nottingham Avenue, Los Angeles. Address of the Chairman on Publicity: Mrs. William C. Boeck, 712 North Maple Drive, Beverly Hills.

For roster of officers of state and county auxiliaries, see advertising page 6.

American Medical Association asks of the Auxiliary; toward public health work through various channels in contact with the public. The *Courier* is to be published in October and April; subscriptions to the *Bulletin*, the national Auxiliary publication, were urged; and plans are well under way for the convention at Del Monte in May, 1941.

Mounting activity of all committees was evidenced by the unanimous decision to purchase a mimeograph with which to lighten the load of the many identical letters, outlines of plans and instructions which must go out to the twenty-eight county auxiliaries, not only from the president, but also from the various state committee chairmen. The mimeograph is to be in the charge of the corresponding secretary, each committee chairman to be responsible for cutting her own stencil and forwarding that to the corresponding secretary with requests for copies.

A delightful luncheon in the dining room, overlooking Lake Merritt and the Piedmont hills beyond, was arranged by Mrs. Charles C. Hall, a Board member from Alameda County.

At the close of the meeting the entire group motored to the hillside home of Mrs. Hobart Rogers, former state president, for a beautiful tea hour. Mrs. Rogers was assisted by Mrs. William H. Sargent, also a former state president; Mrs. Frank Baxter, former State Board member; Mrs. George Calvin, former Alameda County president; and by other members of the Alameda County Auxiliary.

Plans and Projects for 1940-1941

By MRS. A. E. ANDERSON, President

1. To never forget that we are working at all times under the approval and advice of the Council of the California Medical Association.

2. To always keep in mind the objects of the Auxiliary as stated in Article II of the Constitution: "The objects of this Auxiliary are: to bring its members into more active affiliation with organized medicine; to encourage kindly social relationships; to cooperate with the California Medical Association and its component county societies, and other organizations in all desirable public health and social welfare work."

3. To secure the active cooperation of every county unit.

4. Above all, to have a smooth-running organization to more efficiently accomplish the aims and ideals of the Woman's Auxiliary.

5. To increase the efficiency of the county auxiliaries by having group meetings of all the nine districts. At these meetings to have the officers and chairmen of standing committees of the component county auxiliaries present; to have round-table discussions of problems of the counties; if possible to have a member of the State Board, in addition to the President, to lead these discussion groups.

6. To advocate, as is done in many states, the annual physical examination of doctors' wives. (I believe this would lead other women of great timidity to do the same and thereby prevent many of the tragedies of the middle years.)

7. To aid in the work of the Philanthropic Committee of the California Medical Association in promoting the fund for the aid of the needy and unfortunate members of the profession, as provided in Resolution No. 33, passed by the House of Delegates in May 1940 at Coronado.

8. To promote *Hygeia*.

9. To urge members to commit to memory the platform of the American Medical Association, as urged by its president, Dr. Nathan Van Etten.

10. To pledge cooperation with Dr. Philip K. Gilman, the Chairman of the California Committee on Medical Preparedness for National Defense, in whatever he asks the Auxiliary to do.

11. To cooperate with the National President and National chairmen of committees in advancing the work of the Woman's Auxiliary.

By striving humbly to follow these aims with tolerance for the ideas of others and charity for our neighbors, we may attain our goal of helpfulness to our State and National Medical Association.

NEVADA STATE MEDICAL ASSOCIATION

C. W. WEST, Reno.....President
H. A. PARADIS, Sparks.....President-Elect
HORACE J. BROWN, Box 698, Reno.....Secretary-Treasurer

Official Call: Annual Session

To the Officers and Members of the Nevada State Medical Association:

The thirty-seventh annual session of the Nevada State Medical Association will be held at Las Vegas on October 10 to 12, 1940.

All active and honorary members are cordially invited to be present, as well as others who receive this notice.

Headquarters will be at the Elks Club, and the secretary of the Entertainment Committee, John R. McDaniel, Jr., will make hotel reservations for all those who wish them.

C. W. WEST, President.

Attest:

HORACE J. BROWN, Secretary-Treasurer.

Injection Treatment of Hernia Not Advisable for General Use.—The injection treatment of hernia is not advisable for general use and should be employed only by those with special experience and with full understanding of the dangers involved, the Council on Pharmacy and Chemistry of the American Medical Association warns in *The Journal of the Association*.

The Council's statement confirms a previous opinion based on the results of a questionnaire which was sent in 1936 to a selected list of hospitals throughout the country in order to obtain information as to the extent of the use of the injection treatment for hernia, its safety and effectiveness, the incidence of unfavorable complications and the nature of these complications. To keep the Council's information up to date, the same questionnaire has been addressed again to those hospitals which replied to the first one.

After consideration of the second hospital survey and the reports in the recent literature, the report says, "the Council now concurs in the opinion that the method involves less danger of serious complications than surgery when employed only in selected cases of hernia by those skilled in the injection of suitable standardized solutions of known composition and action. The Council is not, however, willing to recognize any such solutions for New and Nonofficial Remedies until sufficient follow-up experience in their application has been gained to establish the success of the injection method of treatment. Present evidence indicates that better types of solution are to be desired."

Never attempt to bear more than one kind of trouble at once. Some people bear three kinds—all they have had, all they have now, and all they expect to have.—Edward E. Hale.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.†

California Medical Association, Hotel Del Monte, Del Monte, California, May 5-8, 1941.

American Medical Association, Cleveland, Ohio, June 2-6, 1941.

American College of Physicians, Statler Hotel, Boston, April 21-25, 1941.

American College of Surgeons, Chicago, October 21-25, 1939.

Medical Broadcasts.*

American Medical Association Broadcasts: "Medicine in the News."—The American Medical Association and the National Broadcasting Company have announced "Medicine in the News," on timely topics from medical news of the week. Thursdays, 4:30 p. m., Eastern standard time (1:30 p. m., Pacific standard time), Blue Network, coast to coast. Thirty weeks. Opened on November 2, 1939. Facts, drama, entertainment, music.

Pacific States:

KECA	Los Angeles	KTMS	Santa Barbara
KFSD	San Diego	KEX	Portland
KGO	San Francisco	KJR	Seattle
	KGA	Spokane	

Los Angeles County Medical Association.

The radio broadcast program for the Los Angeles County Medical Association for the month of October is as follows:

Wednesday, October 2—KECA, 11:15 a. m., The Road of Health.
 Saturday, October 5—KFI, 9:45 a. m., The Road of Health; KFAC, 10:15 a. m., Your Doctor and You.
 Wednesday, October 9—KECA, 11:15 a. m., The Road of Health.
 Saturday, October 12—KFI, 9:45 a. m., The Road of Health; KFAC, 10:15 a. m., Your Doctor and You.
 Wednesday, October 16—KECA, 11:15 a. m., The Road of Health.
 Saturday, October 19—KFI, 9:45 a. m., The Road of Health; KFAC, 10:15 a. m., Your Doctor and You.
 Wednesday, October 23—KECA, 11:15 a. m., The Road of Health.
 Saturday, October 26—KFI, 9:45 a. m., The Road of Health; KFAC, 10:15 a. m., Your Doctor and You.
 Wednesday, October 30—KECA, 11:15 a. m., The Road of Health.

Vitamin Chart.—Copy of a revised Weston-Levine Vitamin Chart has been received from Roe E. Remington, Professor of Nutrition, Medical College of the State of South Carolina, Charleston, South Carolina. Copies are for sale at ten cents each.

Physicians who are interested will find the chart to be convenient.

† In the front advertising section of *The Journal of the American Medical Association*, a different roster of national officers and organizations appears each week, each list being printed in revised form about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Government to Need Temporary and Part-Time Civilian Medical Officers.—The expansion of the army creates a need for about six hundred civilian medical officers in various grades for temporary and part-time service. The duties of full-time officers will be to act as doctors of medicine in active practice in hospitals, in dispensaries, and in the field. The duty of part-time officers will be to report for sick call at a fixed hour each day and to be subject to emergency call at all times.

The Civil Service Commission in making this announcement calls particular attention to the fact that part-time officers will be able to continue their regular practice. In order that this may be done, appointments to the part-time positions will be made of medical officers in the vicinity of the place of duty.

Information concerning these positions may be obtained from the secretary of the Board of United States Civil Service Examiners at any first- or second-class post office, or from the United States Civil Service Commission, Washington, D. C. Physicians are urged to apply at once. This work is of the greatest importance to the success of the National Defense program.

Grant Provides Continuance of Vital Child Study.—Continuation and extension of critical and comprehensive studies, already under way, on the mental and physical development of school children have been made possible for the Institute of Child Welfare of the University of California through a grant of \$61,700 by the General Education Board.

Under the grant a research center will be opened by the Institute on September 1 at 2241 College Avenue, in Berkeley, supplementing the present offices of the Institute on Bancroft Way. This additional building will contain library facilities for the use of students in the field of child development and statistical and research offices for members of the staff, graduate students, and other members of the university faculty who desire to use the Institute's facilities.

One of the specific studies to be pursued under the grant deals with the analysis of physical changes as shown by growth in height and changes in body proportions, physiological maturing as revealed by measurements of x-rays of the bones and assessments of physical ability and efficiency based on various functional tests and laboratory records of physiological changes during exercise. These various indices of the development of body structure and functions are being considered with reference to collateral changes which may occur in psychological characteristics, such as interests, attitudes, emotional traits, and other aspects of personality.

The grant will be administered under the direction of Dr. Harold Ellis Jones, Director of the Institute, and will cover a four-year program. In discussing the program, Doctor Jones said:

"The majority of previous studies in this field have dealt with specific aspects of development and have been limited to problems and methods which lie within the individual fields of psychology, physiology, physical growth, etc. There remains, however, an important task of investigating interrelationships involving these various fields."

Refresher Course: University of California Medical School.—The University of California Medical School is making plans for an intensive refresher course on "The Clinical Aspects of Dermatology." This will be held in Toland Hall, University of California Hospital, San Francisco, from January 6 to 8, 1941, inclusive. The program, which is now being prepared, will cover various common skin conditions, including tumors. Surgical aspects of dermatological problems will be considered and there will be lectures on infectious diseases.

The Dean's Office, University of California Medical School, Medical Center, San Francisco, upon request will be glad to supply any physician with more complete information about the course.

Foundation Gives Cancer Research New Impetus.—Cancer research on the campus of the University of California has been given new impetus by the award of three Finney-Howell Foundation fellowships to members of the staff of the Radiation Laboratory. One of the three fellowships, that held by Dr. Paul C. Aebersold, research fellow in roentgenology, has come to him for the past three years. The other two, to Margaret N. Lewis, research fellow, and to Dr. Alfred G. Marshak, research associate in the Radiation Laboratory, come to the University for the first time this year. As far as is known, California is the only university to hold three of these fellowships at one time.

The Foundation was established through the will of Dr. George Walker, noted gynecologist at Johns Hopkins University, and named in honor of two of his associates, Dr. J. M. T. Finney, gastric surgeon, and Dr. William Henry Howell, physiologist. The amount provided was in the neighborhood of \$300,000, and it was stipulated that the total amount must be expended and the Foundation liquidated in ten years. This was done to accelerate the research activities under the Foundation and to achieve helpful conclusions in the shortest possible time. While none of the three doctors identified with the inauguration of the Foundation specialized in cancer work, they realized the necessity of intensive research in cancer cause and therapy.

Pacific Association of Railway Surgeons.—The thirty-eighth annual convention was held at Reno on September 20 and 21. The program, which was held in the State Building, follows:

Friday, September 20

Presidential Address, "What it has Meant to Me to be a Railroad Surgeon," by William Louis Weber, M. D., Los Angeles.

"Antiseptics and Chemotherapy," by Chauncey D. Leake, Ph.D., San Francisco.

Round Table: "Lesions Above the Diaphragm," by Doctors Robert A. Peers, Chairman, Colfax; William B. Faulkner, Jr., San Francisco; Bernard Kaufman, San Francisco; William L. Rogers, San Francisco; and Hans E. Schiffbauer, Los Angeles.

Address: "The Psychology of the Claims Adjuster," by Mr. Samuel A. Bishop, Los Angeles.

Saturday, September 21

Address: "The Organization of a Medical Department in War," by Lieutenant-Colonel Norman T. Kirk, U. S. A., M. C., San Francisco.

Round Table: "Lesions Below the Diaphragm," by Doctors Alton R. Kilgore, Chairman, San Francisco; Emmet Allen, San Francisco; Vernon Cantlan, Reno; and Colin C. McRae, San Francisco.

Symposium on Shock:

Chemical Aspects by Dr. T. Eric Reynolds, Oakland.
Clinical Aspects and Treatment, by Dr. Clayton Lyon, San Francisco.

Incidence of Syphilis.—Under existing preventive and control measures, at least one of every ten adults living in Washington, D. C., will acquire syphilis some time in life, the United States Public Health Service reported recently after a survey of venereal disease cases under treatment in the nation's capital. . . .

From an economic point of view, the study reveals that the prevalence rate for venereal disease among Washingtonians earning less than \$1,000 per year is 34.6 per one thousand persons. For persons receiving \$1,000 to \$2,999, the rate drops to 6.4 per one thousand persons. Persons with incomes over \$3,000 have a rate of 4.7 per one thousand.

"Only one person in five of those who seek treatment for syphilis does so when the disease is in the early stages," the report emphasizes. "Every infected person who neglects treatment during the first year of the disease represents a potential new case of syphilis. The preponderance of cases in the later stages emphasizes the need for more effective epidemiologic practices. Case-finding is an expensive, time-consuming, arduous task, but it returns big dividends in terms of syphilis control."

"Pay-Your-Doctor Week."—"Pay-Your-Doctor Week," inaugurated two years ago by the California Bank in Los Angeles on a purely local basis will be observed this year from October 27 to November 2 in scores of cities throughout the country, with banks in the various communities sponsoring the movement.

Recognizing the fairly widespread tendency to regard doctor bills as obligations that can wait indefinitely or at least until all other bills have been paid, "Pay-Your-Doctor Week" is proclaimed in order to call attention to the plight of many doctors who, to their great inconvenience, are on call twenty-four hours of every day but who are often paid at the convenience of their patients.

Because "Pay-Your-Doctor Week" was originated by a bank without the assistance of the medical profession, no question of ethics is involved and the movement has been hailed with favor by members of the medical fraternity everywhere.

Banks who sponsor "Pay-Your-Doctor Week" in various cities throughout the country publicize the idea widely, using newspaper advertisements, billboards, car cards and the like, to call attention to the occasion and to the fact that banks have on hand funds to lend for the excellent purpose of paying doctor bills.

Health Held to Be as Important as History.—A proposal that health be placed on an equal rating with history or with any other formal subject in the curricula of the colleges and secondary schools, was set before a special conference on health education on the campus of the University of California. The conference was conducted by the university's School of Education under the sponsorship of the California State Department of Public Health. The conference leader was Dr. Mayhew Derryberry, senior health education analyst of the United States Public Health Service.

The discussion of the introduction of health instruction into other courses brought general agreement among the delegates that health study should permeate every possible phase of instruction. The final consensus was that at the junior high school, high school and college level, health instruction should be included in regular studies and special health courses were also desirable.

The objectives of the program prepared by the conference were to make it possible for every child to develop his inheritance of health, whatever it might be, physically, mentally, emotionally and socially, and to provide in the school curriculum for an adequate community health program.

Central American Doctors to Study at Medical School.—A plan which will enable young Central American physicians to take special training at the University of California Medical School was announced recently by President Robert Gordon Sproul, who is now acting as dean.

According to the terms of the plans, two young graduate physicians who can speak English will be sent every year by each of the Central American nations for two years' special study in preclinical and clinical subjects, under the guidance of an advisory committee.

Central American countries which will send representatives include Costa Rica, Salvador, Guatemala, Honduras, and Nicaragua.

Annual Symposium on Heart Disease.—The San Francisco Heart Committee of the San Francisco County Medical Society will hold its eleventh annual Postgraduate Symposium on Heart Disease on November 26-28, 1940.

Clinics on the various aspects of heart disease will be conducted at the University of California Hospital, Stanford University Hospital, and San Francisco Hospital. The course will include demonstrations of patients presenting problems in the various types of heart disease, discussion and evaluation of specific diagnostic procedures and therapy and differential diagnosis, and treatment. There will be ward rounds, and special classes in x-ray, fluoroscopy, and electrocardiography.

On November 27, in collaboration with the symposium, a morning and an afternoon session will be held at Mount Zion Hospital for the purpose of discussing the public health aspects of heart disease. There is no registration fee in connection with the public health sessions. All who wish to do so are invited to be present.

On the evening of November 27, the annual dinner meeting will be held at the Western Women's Club. A program of unusual interest is being prepared for this annual occasion.

The San Francisco Heart Committee, of which Dr. William W. Newman is chairman, is affiliated with the California Heart Association and the American Heart Association.

Dr. Richard D. Friedlander is chairman of the Program Committee, which is composed of Doctors Francis L. Chamberlain, Gordon E. Hein, William J. Kerr, J. K. Lewis, Charles A. Noble, Jr., J. Marion Read, and Harold H. Rosenblum.

A program with full details regarding the symposium session, registration fees, and other particulars will be mailed on request. Communications should be sent to: Mary B. Olney, M.D., Secretary, San Francisco Heart Committee, 604 Mission Street, Room 802, San Francisco.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

"Life" and Osteopathy*

In *Life*, which is a picture magazine, for August 19 appears an article entitled "Osteopathy's 'Cure-by-Manipulation' Is Attacked by Regular Physicians." Here a small amount of text is supplemented by a number of photographs, evidently made in or supplied through the osteopathic shrine at Kirksville, Mo., known as the Kirksville College of Osteopathy and Surgery. In the very brief text which accompanies the pictures appear a number of misstatements of fact which, it is not too confidently expected, the magazine may correct. Many of these misrepresentations have been repeatedly exposed in *The Journal*. In the second paragraph of the article, for example, appears this statement:

"In thirty-three states qualified doctors of osteopathy are permitted to practice on equal or almost equal footing with doctors of medicine. Osteopaths can and do deliver

babies, perform surgery, prescribe drugs and take full charge of patients."

The facts are that in only four states (Colorado, Massachusetts, New Hampshire and Texas) for certain, and perhaps in a fifth (Kentucky), may osteopaths now legally prescribe or dispense drugs without restriction. This is true in the first four states mentioned because in those states osteopathic applicants, if licensed at all must meet the requirements exacted of applicants to practice medicine generally. To this list may be added, after November 1, 1941, a sixth state (New Jersey), where osteopaths licensed after that date will be subject to the same requirements as nonsectarian applicants and will receive an unlimited license to practice medicine.

Experience has shown that few osteopaths indeed are able to meet the requirements exacted of applicants to practice medicine generally.

In twelve states, osteopaths are given limited right to use certain drugs, the drugs concerned varying in the various states.

In eight states, osteopathic licentiates generally may not use drugs, but the laws contain provisions whereby osteopaths may, under certain conditions, obtain licenses by virtue of which they may use drugs, the law of one of these states even then permitting the use only of a very limited number of drugs.

In eight states, osteopaths are specifically denied the right to use drugs.

In nine states, osteopaths secure licenses only to practice osteopathy, without defining the scope of the practice permitted, but no court has ever held that the right to practice osteopathy includes the right to use drugs.

In seven states, osteopaths are licensed to practice osteopathy as taught in recognized schools of osteopathy which, in effect, denies them the use of drugs, and the Supreme Court of Kansas has recently held that the right to practice osteopathy as taught and practiced in recognized schools of osteopathy confers no right on osteopaths to practice operative surgery or to use remedial drugs.

To summarize:

In twenty-four states, osteopaths legally cannot, under any circumstances, use drugs. In eight states by far the greatest number of osteopaths cannot use drugs, but it is possible for candidates possessing stated qualifications to obtain that right. In twelve states osteopaths may utilize stated drugs to a limited extent. Only in five states, probably, may osteopaths use drugs without restriction. Obviously, then, from the standpoint of the right to use drugs, which an osteopath must possess if he is "to practice on equal or almost equal footing with doctors of medicine," the article in *Life* is, to put it charitably, indulging in gross exaggeration, when it states, "In thirty-three states, qualified doctors of osteopathy are permitted to practice on equal or almost equal footing with doctors of medicine."

* * *

War Time Casualties

In all wars more soldiers have always died of disease than from violence. In the last World War a third more fell before the microbe than perished at the cannon. The casualty list showed 2,215 officers dead in battle, 2,605 in bed; and among the troops the ratio was 48,295 against 65,519.

It will not be permitted to happen again here among the guardsmen and draftees who are being called up for training, at least partly as a result of the efforts of an unknown freshman Congressman, Representative Albert F. Austin, a Connecticut Republican. A physician, former health officer, regimental surgeon of the Wolverine Division in the World War, he tucked an amendment into the draft bill which is causing Mr. Roosevelt and the general staff plenty of headaches but may save the trainees from them.

As originally adopted, the Austin amendment would prevent the drafting of anyone for whom there was inadequate housing, light, heat, sewage and hospital facilities approved by the United States Public Health Service. The Administration succeeded in changing the final form of the law so that the Secretaries of War and Navy are personally responsible instead of the Public Health Service.

All Congress has such confidence in the efficiency of the Army and Navy leadership as to be willing to trust it where it would not trust the political management of some other Governmental departments. Confirmation that their trust is justified lies in the fact that the first summons for draftees is being delayed until the Army housing project can be started. Latest inside information is that 400,000 will be called before January 1, and the call will begin about November 15—after the elections are over.

Houses will be provided for all stationed above the latitude of Washington. Tent camps will be built here and farther south. The Army considers tents superiorly healthy where the climate permits because men do not live under such crowded conditions as in barracks.—Paul Mallon in San Francisco *Examiner*, September 25.

* Excerpt from *Journal A. M. A.*, August 31, 1940, page 787.

Health Service System of San Francisco*

Managers of the Health Service System for municipal employees and the employees of the Board of Education of San Francisco have issued a first annual report covering fifteen months of operation of a plan covering 15,000 persons. The information which follows is taken from that report.

The membership was made up of 9,809 employees, 3,124 adult dependents and 1,817 minor dependents. This was an average monthly membership during a period when there was a steady increase in members. The premium for each employee and adult dependent was \$2.50 a month. Minor dependents under 18 years of age were charged \$1.50 a month, and each additional minor dependent \$1.00 a month.

The percentage distribution of expenditures given in the first table was made from the total of the combined funds.

Of the total of \$355,232.77 disbursed for medical care, approximately 68 per cent went for doctor service, 23 per cent for hospitalization and 9 per cent for x-ray, clinical laboratory examinations, ambulance and physical therapy.

Nearly a quarter of a million dollars was paid to doctors during the first year for the treatment of 10,696 individuals. This is 73 per cent of the entire membership. Sixty-seven

Percentage Distribution of Expenditures

Doctors	57.9
Hospitals	19.5
X-ray laboratories	3.8
Clinical laboratories	2.2
Ambulance	0.4
Physical therapy	1.3
Medical overhead	5.3
Nonmedical overhead	7.9
Equipment and alterations	0.5
Unexpended balance	1.2
	100.0

per cent of the employees had the service of a doctor by the end of September, 1939, and that percentage went up to 75 by the end of the calendar year. It was recognized that there was considerable abuse of the system. Nine hundred and eighty-six local doctors and ninety-four out-of-town doctors participated in the Health Service.

The chief complaint of the doctors has been that the monthly value of the unit of service was too low.

Thirteen hospitals received a total of \$81,422.80 for the hospitalization of 1,500 persons during the twelve months ended September 30, 1939. The average cost per case was \$54.28.

Payment to the hospitals is made at the flat rate of \$7.20 a day, regardless of the amount of service used. In some

Payment to Doctors and Value of Unit by Months (October, 1938-September, 1939)

Month and Year	Paid to Doctors	Value of Unit
October, 1938	\$ 13,452.00	\$1.00
November, 1938	17,603.50	1.00
December, 1938	38,063.00	1.00
January, 1939	17,940.75	0.50
February, 1939	18,874.87	0.65
March, 1939	17,801.04	0.50
April, 1939	18,948.17	0.54
May, 1939	19,543.34	0.57
June, 1939	19,630.78	0.57
July, 1939	19,174.62	0.66
August, 1939	20,273.08	0.65
September, 1939	20,451.42	0.67
Total	\$241,756.57	\$0.66

so-called "come and go" cases, in which the patient is confined only part of the day, the full daily rate is not charged.

This entitles the patient to a ward bed, meals, general nursing care, floor supply of drugs and dressings, x-ray and clinical laboratory examinations, use of operating room, administration of anesthetic and various other services. A patient may select a private or semiprivate room by paying to the hospital the difference between the regular ward rate and the rate for any other room he may choose. Many patients chose the higher priced accommodations.

This year's experience has shown that the cost of providing hospital benefits was 46 cents per subscriber monthly, exclusive of overhead.

In November, 1939, several changes were made in the plan. The rate of contribution for all minor dependents

was raised to \$1.50 a month and the following changes in the service were adopted to affect dependents only:

1. Treatment was limited to one year for any one condition, illness or injury.

2. The rate for minor dependents was increased to \$1.50 a month regardless of the number enrolled by the employee.

3. In the future all dependents must have a medical examination before being admitted to the System and any pathologic condition existing at that time will have to be corrected before the person is admitted; or the person may be admitted but the Health Service will not be responsible for the bills for treatment of that condition.

4. No minor dependent will be admitted until attaining the age of one year.

The number of office visits for either dependents or employees for which the Service will be responsible has been limited to five a month. This was a counter proposal to the one made by the doctors' committee that the patient be required to pay for the first two office visits and the first two home visits. Henceforth, all subscribers are to be restricted to the service of one doctor a month except with the consent of the medical director. This was to prevent patients from shopping around for the same condition. Refractors were also eliminated from the benefits beginning with November 13, 1939. The fee schedule was revised to permit the general practitioner to receive more remuneration for his services.

The administration costs were 13.2 per cent, and it is believed that this can be reduced in the future. Demands of osteopaths and chiropractors and practitioners of drugless therapy for a right to practice under the plan are in course of litigation.

The average cost per employee member monthly for medical services is \$1.87, adult dependents \$2.28, and for minor dependents \$2.05.

* * *

Officer Appointments in Reserve Restricted

No new appointments will be made in the Officers' Reserve Corps, with the exception of those in the Air Corps Reserve, Chaplains' Reserve, Medical Corps Reserve, Dental Corps Reserve and Veterinary Corps Reserve, according to Lieutenant General John L. DeWitt, commanding general of this area.

Maximum age limits for appointment are: Air Corps Reserve, 30; Chaplains' Reserve, 42, and the other reserves still open, 35.

Commissions in the Medical, Dental and Veterinary Corps Reserves are restricted to recent graduates of Class A schools who desire extended activity with the regular Army.—San Francisco Chronicle, September 25.

* * *

Professional Men in Napa Meeting

An address on "Human Responsibilities" by Dr. Harry Wilson of Los Angeles, and talks by other prominent guests featured a meeting of more than one hundred doctors, dentists and lawyers and guests of the Napa County Medical Society here last night.

Dr. Harry Wilson, president of the California State Medical Association, flew here from southern California to be the main speaker at the meeting, conducted in the Plaza Hotel by Dr. R. C. Burkett, vice-president of the medical society, in the absence of President Dr. Frank McGreane of Callistoga. Program for the night was arranged by Dr. George Dawson, chairman of the legislative committee of the society group.

Speakers Heard

Speakers at the meeting included Dr. Charles A. Dukes of Oakland, Senator Frank Gordon and Superior Judge Percy S. King. Doctor Dukes, a member of the American Medical Association committee of ten on medical preparedness, described the work done at recent meetings in New York and Chicago, correlating the work of physicians throughout the nation with that of the surgeon general's offices.

Under the plan of medical preparedness, a chairman is named for each county to correlate county work with the State Council of Defense, to handle work and examinations of the draft. Dr. D. H. Murray of Napa is chairman for this county.

Senator Gordon spoke on matters of general legislative interest while Judge King addressed the professional men present showing the links between the work of doctors and lawyers. Ben Read of San Francisco, executive secretary of the Public Health League of California, addressed the meeting on legislation of interest to doctors and dentists.

Short Addresses

Short talks were heard from the following: Dr. George Kress, of San Francisco, secretary of the State Medical Association; Dr. John Green, of Vallejo, councilor of this district for the association; Doctor Madeley, of Vallejo; Dr.

* From the Journal A. M. A., August 17, 1940.

Fred Butler, director of the Sonoma State Home; Dr. Ruggles Cushman, former director at Mendocino State Hospital; Major A. H. McLeish of the Veterans' Home; Dr. Walter Rapaport, present director at Mendocino; Dr. Lowell Brown, president of the Napa-Solano Dental Society; Dr. Rudolph Toller, assistant superintendent of the Napa State Hospital; Dr. L. L. Stanley of San Quentin prison, and Dr. Fred Clark, of San Rafael, secretary of the Marin County Medical Society.—*Napa Register*, September 5, 1940.

* * *

Medical Men Meet Saturday

Placer County Society to Be Hosts to Eighth Councilor District Medical Men at Tahoe Tavern This Week End

A postgraduate medical meeting will be held at the Tahoe Tavern this Saturday afternoon and evening and Sunday morning with the Placer County Medical Society acting as hosts to the members of the eighth councilor district which comprises all of the territory north of the Calaveras County line to the Oregon state line and east of the Sacramento. The district also includes Yolo, Glenn, Tehama, Colusa and Shasta counties.

The Woman's Auxiliary of the Medical Society of the eighth district will also meet at the same time and place. Dr. Frank McDonald, Sacramento, councilor of the eighth district, is chairman of the arrangements.

Medical lectures will be given by distinguished members of the medical staffs of the University of California and Stanford University.

Among other distinguished medical leaders who will attend will be Dr. Henry Rogers, of Petaluma, president-elect of the California Medical Association; Dr. George H. Kress, secretary of the state organization, and Dr. Charles A. Dukes, past president of the California Medical Association.

On Saturday evening a dinner dance will be held with Dr. Robert A. Peers of Colfax acting as toastmaster. The principal speaker at the dinner will be Ben S. Allen, former representative of the Associated Press in London and a close associate of former President Herbert Hoover. Mr. Allen will talk on war time censorship during the first world war.

Dr. William M. Miller of Auburn is president of the Placer County Medical Society, the host organization.—*Colfax Record*, August 23, 1940.

* * *

Utah Man Named Rail Surgeon President

Dr. R. S. Allison of Salt Lake City was automatically advanced to the presidency of the Pacific Association of Railway Surgeons at an executive session this afternoon as the thirty-eighth annual convention of the association ended its business meeting and prepared for a banquet and entertainment program at Lawton's Springs tonight and a barbecue at Calvada tomorrow afternoon.

Doctor Allison advanced to his position as head of the association from the first vice-presidency. Dr. Ralph M. Morrison, Portland, Ore., second vice-president, advanced to the post vacated by Doctor Allison.

Highlights of the scientific sessions which wound up this morning were discussions of diseases above the diaphragm and below the diaphragm at two round tables. Dr. Chauncey D. Leake of San Francisco spoke to the surgeons yesterday on the value of various antiseptics, and addressed the women of the convention on cosmetics at a 10:45 o'clock breakfast at the Riverside hotel this morning.

The development and organization of a medical department in war time was explained to the delegates and guests this morning by Col. Normann J. Kirk, United States Army medical corps of San Francisco.

Entertainment tonight at the banquet will include professional acts. Speaker at the banquet will be Judge Frank H. Norcross. The barbecue tomorrow afternoon at Calvada, Lake Tahoe, will end the convention.

Additional registrations were received this morning, and with delegates, wives, guests, exhibitors and members of the sponsoring Washoe County Medical Association, approximately two hundred are expected at the dinner tonight.—*Reno Evening Gazette*, September 21.

* * *

New U. C. Cyclotron Holds Key to Mystery of Cosmic Ray

It'll Be Built in Three Years

Dr. Lawrence Hopes for Bigger Successes

When Dr. Ernest Orlando Lawrence, the atom smasher, walks around the radiation laboratory on the University of California campus, something beats, insistently, in the back of his mind.

It is the vision of the most powerful atom smasher, scientifically known as the cyclotron, ever conceived in the mind of man.

It will look something like the Taj Mahal with the pinacles lopped off. It will dwarf the present 225-ton cyclo-

tron, now operating in a new building on the campus, by twenty times. Its huge electromagnet alone will weigh four million pounds. The gargantuan cyclotron will permit a frontal attack on a colossal scale against the nuclei of the atoms—so colossal, in fact, it will create 100 million electron volts.

Ready in Three Years

With this gigantic new cyclotron, which is just being started on the hill near the big "C" in back of the campus and will be finished three years hence, Doctor Lawrence hopes to penetrate the secrets of the mysterious cosmic rays by literally creating them in the laboratory.

With it Doctor Lawrence and his fellow worker, Dr. Donald Cooksey, hope to increase the production of practical atomic power and the transmutation of the elements never before dreamed.

Which may give you an insight into the remarkable possibilities of the man and his machine, the scientific aspect of the man whose work in atom smashing won him the 1939 Nobel Prize, the richest and most coveted award available to a physicist; the man whose work with atoms makes him a whirlwind force in the field of science.

What Lies Ahead?

What is the field of this giant cyclotron to end all cyclotrons which will be buried in the hillside a short hike in back of the big "C"?

As Doctor Lawrence puts it, your guess is as good as his. Basic point of the attack with the new \$1,250,000 cyclotron will be to study the enormous binding energies which link protons and neutrons in atomic nuclei and thus hold matter together into a stable form which we recognize as a table, a piece of salt or any element or chemical compounds. . . .

To understand the nucleus of an atom, Doctor Cooksey suggests you think of a fly in a cathedral. The atom is the cathedral. And the nucleus—yes, it's that small—is the fly. By a process of ionization the fly is freed from the cathedral (atom). First, 200,000 volts of energy are shot into the chamber and the nuclei cross a space of several feet in only 20-millionths of a second. By alternating currents on the plate the volt energy is increased, the nuclear force grows greater and greater.

It acts like a child in a swing, Doctor Cooksey tells you. The electric field in synchronization gives the nuclei an added push. In short, with the same amount of energy applied at the right time the nuclear force becomes tremendous. The nuclei travel at a speed of something like 60,000 miles per second.

Unlimited Discoveries Seen

By the energetic bombardment of elements and substances with particles accelerated in a 2,000-ton cyclotron it is not exactly day-dreaming to expect the field of medical and physical science to reach points of great magnitude.

Now, are Doctor Lawrence and his fellow physicists around the University of California day-dreaming when they see almost unlimited discoveries in the world of science just three years away—when that gargantuan "plaything" atop Strawberry Hill starts pounding atoms as they've never been pounding before?—*San Francisco News*, September 11.

* * *

Medical Group to Aid Defense

Chicago (UP).—This country's defense preparations must include a medical program as well as appropriations for increased armed forces, according to the *Journal of the American Medical Association*.

To facilitate the medical profession's part in the defense program, the *Journal* said, a committee of medical preparedness has been created by the American Medical Association to cooperate with the Advisory Committee on National Defense, the Army and Navy Medical Corps and the Public Health Service.

The committee is composed of fifteen physicians practicing in various sections of the country and is headed by Dr. Irvin Abell, Louisville, Ky.

Its functions include:

1. Consideration of problems involved in supplying adequate medical personnel for military, naval and civilian needs under any contingency.
2. Provide for adequate personnel to handle physical examinations, particularly of men conscripted for the medical service, men assigned to vocational training and persons on relief.
3. To represent the association in conferences with the surgeon generals of the Army, Navy and Public Health Services, and with other governmental agencies.
4. To cooperate with state committees on medical preparedness.

5. To receive recommendations from state committees on physicians whose services are believed necessary for maintenance of civilian health and who should, in the opinion of the committees, be exempt from military service.

6. To assist in the verification of qualifications of physicians desired for service in the army or other national defense work.

The *Journal* of the American Medical Association in announcing the composition of the national committee, gives as its aim "to prepare our nation to meet any emergency."—*Riverside Enterprise*, September 9, 1940.

* * *

City Health Plan Revision Asked

Doctors Seek Adjustment in Scale of Fees by City Workers

A charter amendment granting San Francisco doctors a voice in the affairs of the Municipal Employees' Health Service System will be introduced in the Board of Supervisors today.

In behalf of the physicians and surgeons who provide medical care for the 15,000 city employees and dependents served by the System, the amendment is sponsored by the San Francisco County Medical Society.

The amendment would:

1. Grant doctors the right to petition for changes in the System's operation (within limits of the charter section creating the System) and require the Health Service Board to consider such petitions.

2. Empower the City Retirement Board to modify, as well as approve or disapprove as at present, Health Service Board action on contracts.

3. Bring the System's hospitalization arrangements into conformity with the State Insurance Code.

4. Provide for annual review of medical and surgical compensation schedules.

On November 5 Ballot

If submitted by the Board of Supervisors, the amendment will appear on the November 5 ballot.

Dr. William Reilly, President of the County Medical Society, said yesterday:

"By some chance, when the original charter amendment creating the Health Service System was drafted, the doctors whose services make the System possible were excluded from any participation in the System's affairs.

"During the two years the System has been operating, this situation has been the source of much friction and discontent. We doctors have had no right to initiate changes in methods or procedures whether we believed them in the interests of the patients or of the doctors themselves. We have had to assume the attitude of supplicants outside the doors of the Health Service Board and its medical director.

"Nearly nine months ago, for example, we requested, and the Retirement Board directed, the Health Service Board to discuss with us certain revisions of our fee schedule. These revisions concerned only the doctors, involving a redistribution of available medical funds among the doctors themselves. Not a cent of additional money was asked.

"Yet, after nine months, we are still seeking the Health Service Board's permission to effect this redistribution. Only the other day, the Board told us we had not followed the correct procedure to obtain this permission and that we must start over again.

"The value of our professional services to the System—we gave more than \$132,000 worth of free medical service to members of the System in the first year—the integrity and dignity of the medical profession entitle us to greater consideration than this.

Doctors Ask Voice

"The time has come to grant the doctors a definite, if small, voice in the affairs of the System itself, the right to initiate and press to a conclusion matters which the doctors believe will contribute to the System's efficient operation. That's what this charter amendment is designed to do.

"The Health Service Board has pending before the Board of Supervisors another charter amendment to make its employees subject to the Civil Service and retirement benefit provisions of the charter. We do not intend to oppose that amendment. We hope the Board will not oppose ours."—*San Francisco Examiner*, September 10.

* * *

Barristers Club Health Service Plan Meeting With Wide Endorsement

Registration Ends Soon

Urging all members of the Barristers Club to participate, Fred S. Farr, past president, yesterday announced the deadline for the California Physicians' Service had been extended to September 15.

More than forty-five members of the club have already applied for service facilities, Farr said. Forty per cent of the club's membership must sign before the service becomes available.

The plan, which costs \$2.50 per month, includes health, accident and hospitalization and has been endorsed by the California State Medical Association, Harry S. Young, President of the Bar Association, and other leading lawyers.—*San Francisco Recorder*, September 5, 1940.

* * *

Geiger Against Charter Change

Wouldn't Use Hospital for Paying Patients

Health Director J. C. Geiger today opposed a proposed charter amendment which would open San Francisco Hospital to paying patients after all indigent cases have been accommodated.

"San Francisco Hospital is financed by the taxpayers to care for the indigent poor and is the finest institution of its kind in the nation," he said. "Private hospitals are doing an excellent job of caring for those who are able to pay and should not be in competition with a tax-supported institution."—*San Francisco Call-Bulletin*, September 5.

* * *

Institutions Separated From Other Charities

Hospital, Sanatorium and Poor Farm to Be Under Director Responsible to County Board

Action to separate the three major county charity institutions from the Los Angeles County Department of Charities and place them under a director without the necessity of a County Charter amendment and still keep within the law, was taken yesterday by the Board of Supervisors.

The institutions to be affected are the Los Angeles County General Hospital with an annual budget of \$5,500,000; Olive View Sanatorium for the treatment of indigent tuberculosis cases with a yearly budget of \$1,650,000, and the County Poor Farm, known as Rancho Los Amigos, with a budget of \$1,550,000.

Answerable to Board

All three will be under the supervision of the County Superintendent of Charities, as required by law, who will be a director directly answerable to the Board of Supervisors.

The other activities of the Charities Department, with the institutions out, will be under the supervision of a County Director of Public Assistance, the new title to be created by a county ordinance to be adopted by the Board of Supervisors. These activities will include old-age pensions, child and blind aid, direct relief, etc.

Plan of Allen

The action of the supervisors was taken on the recommendation of County Manager Wayne R. Allen, who declared that the new arrangement would create a saving of at least \$50,000 annually for the taxpayers of the county. It can be done, too, he said, without the necessity of a vote on a charter amendment as the institutions will be under the County Superintendent of Charities as the law requires.

Supervisor Gordon L. McDonough's proposal of a charter amendment to place the General Hospital in a separate county government department was voted down, 4 to 1.

Other Recommendations

The move of the Board of Supervisors to divorce the institutions from the Charities Department follows, to some extent, the recent recommendation of the Health and Welfare Committee of the County Grand Jury, which suggested a commission of seven members be created to supervise them. . . .—*Los Angeles Times*, September 11.

LETTERS

Concerning a Series of Lectures to Lay Audiences.

During the past several years the central office of the California Medical Association has cooperated with the Young Women's Christian Association of San Francisco by securing speakers for a lecture series that is given once or twice yearly.

Excerpt from a letter follows:

(COPY)

San Francisco, September 7, 1940.

Dear Mrs. McFarland:

Referring to our previous correspondence concerning lectures to be given at the Y. W. C. A., I am sending this additional information concerning the topics suggested by you.

The guest speakers and the topics they will discuss are as follows:

September 19—"Understanding Yourself and Others," John Alden, M. D., San Francisco.

September 26—"Learning to Relax," Ernest Lion, M. D., San Francisco.

October 3—"Learning to Live with Propaganda," W. A. Oliver, M. D., San Francisco.

October 10—"Mobilizing Your Emotional Forces (Mental Hygiene in Daily Living)," Helen L. Starbuck, M. D., Stockton State Hospital, Stockton.

As I understand the plan, the talks are to be of about forty-five minutes' duration, with allowance of fifteen minutes for subsequent questions and discussions. . . .

If we can be of further service, kindly inform us.

Cordially yours,

GEORGE H. KRESS, M. D.,
Secretary.

Concerning Cards of Physicians in Newspapers.

(COPY)

BOARD OF MEDICAL EXAMINERS

STATE OF CALIFORNIA

Sacramento, California,

August 16, 1940.

Subject: Yours of August 9, Re Newspaper Advertising.

Dear Doctor ———:

Pardon this belated answer to your query of August 9 as to whether "it is ethical for a physician to have a 'card' in the local papers, stating his hours and giving the address of his office."

In so far as is concerned the administrative work of the Board of Medical Examiners, there is no legal objection to a professional card in a newspaper relating the full name of the individual, suffix designating the degree which he holds, a statement as to the license issued to him, his address, office hours, and telephone number.

The question of ethics of such a card is within the province of the California Medical Association, George H. Kress, M. D., Secretary, 450 Sutter Street, San Francisco.

Awaiting your further pleasure, believe me

Very truly yours,

C. B. PINKHAM, M. D.,
Secretary-Treasurer.

c/o California Medical Association
George H. Kress, M. D., Secretary
450 Sutter Street
San Francisco, California

✓ ✓ ✓

San Francisco, August 20, 1940.

Dear Doctor ———:

Doctor Pinkham has sent to us a copy of his letter of August 16, on the subject of cards in local newspapers.

I am sending you a copy of the American Medical Association "Principles of Medical Ethics." On page 7, under Section 4, you will find a discussion of "advertising."

If we can be of any further service, kindly inform us.

Cordially yours,

GEORGE H. KRESS, M. D.,
Secretary.

Concerning Letter of Committee to Defend America.

EUGENE S. KILGORE, M. D.

490 Post Street

San Francisco, September 25, 1940.

To the Editor:—This is the letter of which I spoke—for publication in CALIFORNIA AND WESTERN MEDICINE.

It went to 140,000 United States physicians (those more than five years in practice). Thank you!

EUGENE KILGORE.

COMMITTEE TO DEFEND AMERICA BY AIDING THE ALLIES

(William Allen White, National Chairman)

8 West Fortieth Street, New York

Dear Colleague:

If you believe as we do—

That America has long been in this war in the rôle of sleeping prospective victim;

That the struggle for freedom abroad is a delaying action in our war;

That the British fleet is our present chief defense; and

That our wish to *Keep the War Out of America* can best be favored by *all possible* aid to Britain—"possible" meaning within the discretion of our state and service departments, freed from needlessly restrictive legislation.

If you believe these things, we invite your active participation in the work of this Committee. There is much to be done. *First*, enroll with your local branch or start one in your community—to keep in touch with rapidly changing events and needs for action. Write to the Committee for information.

Second, make your influence count. This means, at the moment, your own letters or telegrams to presidential candidates and congressmen; then letters from as many other persons as you can influence—brief letters, stressing the need for utmost possible aid. President Roosevelt should be addressed at the White House, Wendell Willkie at Republican Headquarters, New York, your senators at the U. S. Senate, and your representative at the House of Representatives.

And, *third*, will you send a contribution today to the Committee so that it may expand and intensify its work in arousing America from its rôle of sleeping prospective victim. With nation after nation it has been "too little and too late." Please make checks payable to Frederick C. McKee, Treasurer, and send to the Committee in the enclosed envelope.

Sincerely yours,

Subcommittee for Medicine

Emile Holman, M. D. Warfield T. Longcope, M. D.

Eugene S. Kilgore, M. D. J. H. Musser, M. D.

Roger I. Lee, M. D. D. B. Phenister, M. D.

Ray Lyman Wilbur, M. D.

P. S. Tentative plans are forming to circularize other professional and nonprofessional groups. Much will depend upon the response of the doctors. If you are in accord with our purpose, your immediate reply will be most helpful.—Committee.

Concerning "Hygeia": Special Subscription Price.

AMERICAN MEDICAL ASSOCIATION

535 North Dearborn Street, Chicago

Dear Doctor:

Imagine two million people reading *Hygeia* in their physicians' offices each month. A lot of people . . . a powerful influence for scientific medicine . . . but not imaginary!

Recently we made two independent surveys of physicians' waiting-rooms to see how many patients actually read *Hygeia*. The results were amazing! They showed a monthly readership of two million . . . and more than that, indicated that each person spent an average of fourteen minutes with *Hygeia*.

Certainly your office can and should share in this great influence. To show you how important we think it is for you to have *Hygeia* on hand, we make you this attractive offer . . . a subscription to *Hygeia* for the remainder of

this year and the whole of 1941 (16 issues) for only \$1.75. A saving of 50 per cent . . . 16 issues at the regular subscription rate would cost you \$3.50.

Hygeia is published by your own American Medical Association to help educate the layman to sane, healthful living. It is your ally in promoting scientific truths . . . in discouraging self-medication . . . in combating quackery . . . and in overcoming fears and superstition. What better way to give your patients the kind of helpful, authentic health information you want them to have?

All in all, Doctor, this is a rare bargain . . . your opportunity to get *Hygeia* at half-price . . . and at the same time get full advantage of its real influence among patients. Why not fill in the enclosed card and mail it with your check for \$1.75 today?

Very truly yours,

AMERICAN MEDICAL ASSOCIATION.

FRANK V. CARGILL,

Circulation Manager, Hygeia, The Health Magazine.

Symptoms of War Gases: Their Treatment.

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

September 13, 1940.

To the Editor:—Enclosed you will find a chart showing the name and description and giving symptoms and treatment of war gases which has recently been incorporated in the book of instructions for use in the San Francisco Emergency Hospitals.

Central Office, 101 Grove Street.

Sincerely,

J. C. GEIGER, M.D.,

Director of Public Health.

Concerning a Letter Received by a California Physician.

The following letter was sent to the California Medical Association central office by a member of the Association:

(COPY)

Palo Alto, California, September 3, 1940.

To the Editor:—This letter that I am enclosing has aroused my curiosity. Frankly, I am not at all interested in answering it. I wondered, however, if you could give me any information about the company. It must be a remarkable piece of machinery that can give so much for nothing.

Thank you for any facts you can give me.

Sincerely,

The enclosure letter to which reference was made follows:

(COPY)

Letterhead of Company, etc.

Dear Dr. ———:

We have a very favorable report concerning your standing as a young, progressive doctor, and would like you to serve on the National Advisory Board of a nonprofit Disability Foundation being organized which will have headquarters in your part of the country.

Its purpose will be to pay incomes to individuals who become totally and permanently disabled through any cause, including any accident, any sickness, mental disorders, military service, or invasion. Such protection has been practically unobtainable from insurance companies for some years past.

The protection will be offered by the Foundation as a public service at the lowest possible cost. It is intended to

War Gases			
Name	Dispersed Form	Symptoms	Treatment
LACHRYMATORS (TEAR GASES)			
Acrolein Benzyl bromid Chloracetone Chloracetophenone	Gas Liquid Solid Solid	Profuse lachrymation; smarting and burning pain in eyes; blurred vision; photophobia.	Wash eyes with 1 per cent sodium bicarbonate solution. Dark glasses.
LUNG IRRITANTS			
Phosgene Chlorpicrin Falite Superpalite	Gas Liquid Liquid Liquid	Dizziness; grey cyanosis; marked cyanosis on exertion; coughing; marked dyspnea with bronchospasm; nausea and vomiting; early, intense pulmonary edema; acidosis; unconsciousness; collapse; death from asphyxia.	Bed rest; keep warm; oxygen inhalation; venesection. Morphine for restlessness. Sodium bicarbonate or physiologic salt solution intravenously. Caffeine, metrazol or digitan hypodermically, if necessary.
SENSORY IRRITANTS (SNEEZING OR VOMITING GAS)			
Diphenylchlorarsin	Dust or Toxic Smoke	Violent sneezing; coughing; nausea and vomiting; dyspnea; congestion or edema of lungs.	Irrigate nose and mouth with physiologic salt solution. Rest. Oxygen inhalation, if necessary.
SKIN IRRITANTS AND VESICANTS			
Dichlorethylsulfid (mustard gas) Chlorvinylidichlorarsin (Lewisite)	Liquid Liquid	Dermatitis, itching, skin blisters; blindness; blurred vision; sneezing; retching and vomiting; dyspnea; incapacity; restlessness; cyanosis; collapse, shock. Death from asphyxia.	Wash eyes with physiologic salt solution containing 1 per cent sodium bicarbonate. Cleanse skin with bicarbonate solution, followed by application of bleaching powder paste, made with equal parts of water or Chloramin-T, 1 to 2 per cent; rinse skin. Apply benzocaine dusting powder to skin; tannin lotion, if necessary. Treat like burns. Later, treat for lung irritation (see above) and for collapse and shock, if necessary.

supplement, not compete with other types of protection offered by insurance companies and hospitalization plans.

If you will serve on the Advisory Board, the Foundation will give you the disability protection for yourself without charge. May I send you an outline of the plans to assist you in making a decision?

Yours very truly,

(Signed): _____

Concerning Heart Pamphlets Obtainable from the American Heart Association.

Members who wish copies of the pamphlets referred to should write to California Medical Association, 450 Sutter, San Francisco. In due course, request will then be made for the number of pamphlets needed and these will be sent from the California Medical Association office. Letter follows:

(COPY)

August 27, 1940.

To the Editor:—The enclosed pamphlet, entitled *Standardization of Blood Pressure Readings*, is the result of careful study of the problem by Joint Committees appointed by the American Heart Association and the Cardiac Society of Great Britain and Ireland. Leading medical schools and all of the outstanding insurance companies are adopting this method as a standard procedure for teaching purposes and for keeping their records.

A copy of *Examination of the Heart* is also being sent you.

We are endeavoring to give these two pamphlets as wide distribution as possible and we hope that you will cooperate with us. If you will assume the transportation charges, we will gladly send you, with our compliments, as many of each of the pamphlets as you may wish.

AMERICAN HEART ASSOCIATION, INC.

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.

San Francisco

Danger of Suit from Failure to Remove Broken Needle

There are a number of cases which have reached the Appellate Courts and others which have not gone beyond the trial court, in which a physician or surgeon has been charged with negligence for failure to remove parts of a needle shaft which has been broken while inserted in a patient's body. Physicians have at times permitted such foreign objects to remain in the body temporarily or permanently where either the condition of the patient would render a surgical operation at the time dangerous or where the needle is embedded in fatty tissue and likely to cause no harm. As to whether or not the facts in any particular situation will, as a matter of good professional practice, justify leaving the foreign object in the body will not be here discussed. The purpose of this article is merely to show what courts and juries have done in such situations.

In a Texas case decided in 1933, a surgeon had broken a needle while making a spinal injection in his patient's back. Removal of the needle would have required surgery, and the physician permitted the needle to remain, feeling that there was little chance that any pain or harm would come to the patient because of the needle's presence in the fatty tissue of the lumbar region. Three weeks later the patient returned, complaining of severe pains in the area and requesting that the surgeon remove the same free of charge. The surgeon refused to operate without the payment of an additional consideration, so the patient had it removed elsewhere. Suit was later brought against the physician for the cost of the removal operation and for

damages for pain and suffering. The jury found that the defendant had not been negligent in permitting the needle to remain in the area during the three weeks' period, but that when once notified that pain existed, was negligent in not removing the needle at that time and was liable for such pain as occurred thereafter. The liability of the defendant was based upon certain expert testimony to the effect that a broken needle in that region of the back should be removed as soon as possible to prevent its moving around, and that one left near the spine might possibly work its way into the spine and cause paralysis. In the particular instance the needle had worked its way nearly an inch from the point of original breakage.

A California case upon which a jury disagreed was based upon similar facts. A patient of very nervous disposition was given a lumbar injection during the course of which the needle broke off at the hilt and was left just under the surface of the skin. The defendant did not feel that it was necessary to remove the object at the time because of the patient's neurotic condition and for a period mentioned nothing to the plaintiff about the breakage. Later he told her of the breakage but stated that in that particular area there was much fatty tissue and little nerve fiber, and that, therefore, the object could remain indefinitely without pain to her. However, after the object had remained in the patient's back for some time, it was removed by another physician and suit was brought for pain and suffering. Expert testimony was presented on both sides; that of plaintiff tended to show that it is always more or less dangerous to leave a needle within the body, since it might work its way to a dangerous area—that regardless of the relatively few nerve centers in that area, there could have been some pain as a result of the foreign object—and, finally, that good practice requires the use of a needle with a protective shield so constituted that the breaking of the needle at the hilt will leave some portion exposed above the surface of the skin to assist removal. Defendant's experts testified that the type of needle used by the defendant was used in many hospitals and laboratories, that it was accepted by the medical profession as satisfactory; that there are circumstances under which it is not negligence to leave a needle within this area of the body. The jury was unable to agree upon the issue of negligence. Thus, although there was expert testimony tending to show that the defendant was not guilty of any negligence, nevertheless, the jury was not convinced of that fact.

Numerous other cases have dealt with the removal or failure to remove foreign objects from other parts of the body.

In one case, after a defendant physician had operated upon plaintiff, another doctor removed a needle from plaintiff's abdomen. The defendant did not deny performance of the operation or that the needle became embedded in plaintiff's side during the operation; however, he contended that plaintiff failed to establish by expert testimony any malpractice on his part. The jury rendered a verdict for the plaintiff on the theory that expert testimony was not necessary to prove negligence under such facts.

In a Washington case it was held that where a needle was broken during the performance of an operation, a verdict could be rendered where it was shown that the defendant had not made an examination of the needle before using the same.

The result of the decisions concerning broken needles makes it necessary to point out to the profession that there are instances in which the physician may be exercising his best judgment as to whether or not an operation should be immediately performed to remove a foreign substance, and yet be held liable for failure to make such removal. This is true because of the fact that the average jury, made up of laymen, is sometimes shocked by facts which to the medical profession cause no consternation.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XIII, No. 10, October, 1915

From Some Editorial Notes:

Records—Records—Records!—It is hard to make physicians see the importance of anything that looks like business. It is very difficult to make them see the commercial value to themselves of keeping careful and complete records of all their cases. The JOURNAL has repeatedly argued the paramount necessity for keeping such records owing to the increasing habit of the ordinary citizen to "sue the doctor." In fact, it is an open question whether or not the State Society should formulate some rule on this point which would withhold the benefits of its medical defense in suits brought against its members, unless the member can produce a complete and properly kept case history of his treatment of the former patient who brings the suit. . . .

The Safety of Patients.—More and more does it seem that the individual is asserting his inalienable right to seek medical opinion where and when he will; and while this right may not be denied, it is still not good for him. Conditions in connection with this phase of medical life, as in many others, are rapidly changing and while we must, as reasonable human beings, admit and accept such changes, it is well to remember the old order and, particularly, the reasons for the old order of things. Two brains are better than one. From consultation, from the rubbing together of thoughts, come enlightenment. One person suggests what detail fits into the thought of another. Taken separately, and without the interchange of thoughts and comments, the separate examination and opinion of several medical men is not a good thing for the safety of the patient. And that was the reason for the old ethical law or custom that one doctor would not see, examine or express an opinion about the patient of another doctor, save and except when they two were together. It was in the interest of the safety of the patient. Even now, with our changing conditions, it may be possible, sometimes, to make people see the wisdom of this course of procedure.

Doctors and Charity.—To say that the physicians of a community contribute more to charitable work than all the charitable organizations in that community combined, is to make a safely conservative statement of fact. Every physician knows that he will do a certain percentage of his work for which he will never receive any return whatever. All physicians are ready and willing at all times to advise on matters of public health, protection against threatened epidemics, and the like, or to give their actual services and time and effort for the public health of the people of the community in which they find themselves. It is ingrained in medical education and a fixed part of medical life. In view of these facts it has always seemed to the writer that for laymen to ask physicians to contribute in money toward the support of various charitable enterprises, was a sociologic blunder if not an impertinence. The conduct of public health movements, as the war upon tuberculosis, the study and prevention of cancer, and the like, are matters of primary interest to the community as such and their maintenance should be a community burden. If it is not assumed by the community, it should be assumed

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† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.

Secretary-Treasurer

Board Proceedings

The results of the written examination held in Los Angeles on July 16-18, inclusive, show that approximately 110 graduates of medical schools, including some foreign graduates, passed the examination. The highest mark, 90 7/9 per cent, was made by Antonio Alberto Adames, M. D., graduate of the College of Medical Evangelists, June 9, 1940.

News

"Charges that the State Board of Medical Examiners was 'corrupt' and was 'as lawless a body as can be found in the State of California,' and an attack on the 'narrow-mindedness of the medical profession' were made today on the council floor by Councilman Arthur E. Briggs. It arose over a minor change in the ordinance regulating massage parlors and bath houses by including doctors, nurses, and students of medicine under the regulations. The State Medical Board, Briggs charges, operates 'in violation of the law,' and the Council would be 'playing down that Board's alley on this proposal.' He accused the medical board of being corrupt and of having 'no decency,' 'no conscience or charter (character).' At this point, he got into a personal discussion with Councilman Roy Hampton, who defended doctors generally, as well as the state board, and called Hampton 'muddle-headed.' . . . Members of the medical profession, Briggs said, belong to a period of the past, since in its capacity of the 'noble profession of the healing arts' it was still living in the thirteenth century, because of its 'narrow-minded attitude to others with whom it competes.' He took the occasion to apologize for his own profession, that of law, and said he was 'sorry' that his profession was in somewhat a similar position. . . ." (Hollywood Citizen News, August 15, 1940.)

"Motive behind the Government's move to cancel the citizenship of Dr. Herman Frederick Erben, San Francisco brain specialist and authority on tropical diseases, was revealed yesterday. The 43-year-old Vienna-born scientist himself admitted he is under investigation by the FBI and military intelligence service, on reports that he is in some way involved in Nazi espionage work. Doctor Erben said that Federal agents have been investigating his activities—particularly since he came back to the United States after serving as ship's surgeon on the vessel which acted as supply ship to the German pocket battleship *Graf Spee*, blown up in Montevideo harbor several months ago, after she had been riddled and chased into port by British men-of-war. . . . The Government charges that the Austrian surgeon obtained his naturalization under false pretenses, and that he falsified when he swore he had resided continuously here for five years preceding the naturalization. . . . Meantime he frankly discussed his work aboard the *Graf Spee's* supply ship—even to the startling assertion that he, as ship's surgeon, had been supplied with mysterious pellets, to be given out to members of the vessel's crew to swallow in the event they faced capture by the enemy. Doctor Erben, in making his revelations, also bared the fact that he has one son now serving in Hitler's armed

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† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.